ABORTION IN INDIA

AN OVERVIEW

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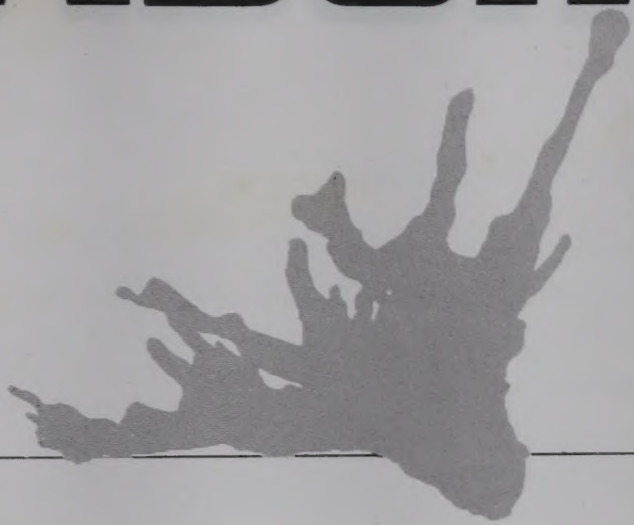

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INTRODUCTION

Indian women remained subject to an archaic and oppressive British-framed law in one of the most important and intimate aspects of their personal life till a quarter of a century after Independence. They lacked the right to relief from an unwanted pregnancy, except in medically-determined, life-threatening circumstance. But when change in this restrictive law came, it was not preceded by protracted struggle - as was the case in many Western countries.

Elsewhere often, abortion has been an extremely emotive issue. In the USA, for instance, it has drawn rigid battle lines between polarised sections of society, erupting centrestage into national electoral politics. There, it appears to have become the metaphor of extremist feminist positions threatening to familial structures and existing societal norms. The unification of the two German states was postponed by several weeks because of disagreement over abortion policy.

In most Western industrialised countries about half of abortions are being obtained by young, unmarried women seeking to delay the first birth. But in most developing countries, as in East Europe, abortion is most common among married women with two or more children.[1] Thus, the nature of the problem is radically different. Abortion is, therefore, not seen as a willful assertion of sexual autonomy, but the woeful consequence of the lack of it; and, of effective, accessible and acceptable contraceptive services.

In India, so far, abortion has largely remained behind a ''social purdah''. If anything, it forms a metaphor of women's acute helplessness, particularly within the ambit of their marital lives. Wide concern and sympathy for this fact at intellectual and political levels resulted in the state's *suo moto* reform at the start of the seventies.

The Medical Termination of Pregnancy (MTP) Act was passed by the Indian Parliament in 1971, to be enforced across the country (excluding Jammu & Kashmir) from Ist April, 1972. In 1980, Jammu & Kashmir (and Mizoram) also adopted the MTP Act. However, it is still not applicable in the state of Sikkim and the Union Territory of Lakshadweep.[2] Thus, a discriminatory legal situation exists for women in parts of the country.

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[1] Henshaw, Stanley K. (1990) ''Induced Abortion - A World Review'', *Family Planning Perspectives*, Vol.22, No.2, p.76.

[2] Govt. of India (1992) *Family Welfare Programme in India, Yearbook 1989-90*, Ministry of Health & Family Welfare, New Delhi, p.229.

More critical is the growing realisation that what was thought to be a landmark in social legisation has failed to translate into reality for very vast numbers of women across the country. The specific purpose of the change in law was to ensure women safe, legal, medical services for pregnancy termination when required. This was done in view of the high incidence of illegal abortions taking place in India in the sixties/seventies, with disastrous consequences to maternal health and well being.

Major Observations from this Study

- ***MTP Act's implementation very poor:***

This overview of the current situation with regard to abortion and the services for medical termination of pregnancy confirms the fears that the law's implementation has been most faulty. Consequently, the MTP Act remains at the realm of good intentions and medico-legal benevolence, with safe services for pregnancy termination outside the reach of far too many.

- ***More illegal abortions today than were happening prior to MTP Act:***

This study finds that the absolute numbers of women requiring MTP services today, and not availing them or not being able to access them, is several times more than is considered to be the case by policy makers and programme implementators. Perhaps because of inadequate perception, the efforts to remedy the dismal situation have been limited in the extreme. Resulting in the current scene, wherein, more illegal abortions are taking place than were happening at the onset of the seventies - when the MTP law was framed to overcome just this predicament.

- ***Official data indicate a total of 0.6 million MTPs annually in 1991-92; but the likely number of abortions are estimated to be over 11 million; nearly 7 million induced:***

The present study estimates the number of abortions now taking place at over 11 million a year, of which 6.7 million are likely to be induced. By contrast, MTP records for 1991-92, which provide the highest figures noted in any year so far, ennumerate 0.6 million MTPs carried out. This indicates a ratio of 10-11 illegal abortions for each MTP.

- ***Likely figure of abortion related deaths 15,000-20,000 a year and significant morbidity; but not showing in official data:***

The study highlights the likelihood of 15,000-20,000 abortion related

deaths annually, based on the Registrar General of India's statistics on abortion contribution to rural maternal deaths. But MTP records document a single-to-double digit-to nil range over the years. It also draws attention to the existence of a submerged iceberg of abortion-related morbidity, largely ignored so far.

- ***Collosal gap between field reality and MTP delivery makes abortion a key, neglected public health issue:***

Abortion, therefore, emerges as one of the most significant, and hitherto, neglected public health issues in India. There is a collosal gap between actual abortion demand and its satisfaction through the legitimate MTP service channels, as evidenced by the public records. A tremendous price is being paid by women for this oversight and indifference.

- ***Abortion, a crucial proxy indicator of a vast unmet need for contraception:***

The very scale of the abortion numbers, makes abortion in India an important proxy indicator of a vast unmet need for contraception - which continues to exist, despite the massive official family planning programme and the strenuous official efforts to promote and provide family planning services.

- ***Abortion, a sensitive indicator of women's conjugal inequality:***

Equally, the size of the abortion problem - as noted further, predominantly, a question of married women with children not wanting more or wanting to space the next - focuses it as a most sensitive indicator of intense gender inequality for most women *within* the conjugal relationship; and, of their lack of "bodily integrity" as an individual human right.

- ***Abortion in India mainly a married, multiparity mother phenomenon;***

Abortion in India in the nineties - this review reaffirms - is principally the burden of the married multiparity mother. Age may have inched down and parity pared a bit over the last two decades, but the essential profile identified in the sixties/seventies: of respectable, married mothers, debilitated and desperate enough from varied personal circumstances to seek relief somehow, remains unvaried. However, this study notes a small, but yet worrisomely significant increase in teenage and pre/extra marital pregnancy terminations, signifiying a negative shakening of social mores. Nevertheless, the overwhelmingly greater burden arises from unwanted and mistimed pregnancies to married couples.

- ***Abortion an universal need cutting across communities, socio-economic, cultural and religious groups:***

The characteristic profile of women seeking abortion in India is of young, married women with at least 2 or more living children, who have failed to use contraception or whom contraceptives have failed; and, who do not want more children, or at any event, at least not yet. Most studies find the socio-economic and religious factors to reflect the general composition of the population, suggesting abortion to be an universal need cutting across communities, classes, and even cultural and religious backgrounds. However, a few studies document lower acceptance of abortion amongst Muslims.

- ***Majority of pregnancy terminations in first trimester; but second trimester terminations high and increasing:***

The majority of women seek termination of pregnancy within the first trimester. Nevertheless, India's incidence of second trimester abortions is noted to be amongst the highest anywhere in the world. It is to be remembered that second trimester abortion is infinitely more hazardous to the woman; and concomitantly, more expensive medically. A matter of acute anxiety is that second trimester abortions are rising in recent years. The causes for this would require more detailed probing. The present study suggests linkages between later termination and increasing teen, pre/extra marital terminations; as also sex-selection based terminations.

- ***High volume of multiparity-linked, plus spontaneous abortions, illuminate the fragile condition of women's reproductive health status:***

The high incidence of marital, multiparous pregnancy terminations, as also the high volume of spontaneous abortions - estimated at 4.5 million - illuminate substantial and unnecessary drain on women's health, further substracting from the already fragile condition of women's reproductive health status.

- ***Rising abortions indicative of social patterns permitting males unbridled sexual gratification without due consideration to spousal well-being and social responsibility:***

Indirectly, the abortion statistics throw into relief the gross male self-indulgence and neglect of spousal well-being and reproductive health aspects. The wife's physical health condition or psychological preparedness to bear a child appear to be of the least consideration in the marital sexual equation,

leaving the woman to her own devices to end an unwanted conception. The enormous numbers of abortions are, therefore, indicative of a delinquent social pattern permitting males an unbridled gratification of sexual urges, minus responsibility and consideration to the partner; as also, the family and community. The scale of pregnancy terminations occurring is, thus, the virulent effect of women's double victimisation.

- ***Abortion issue bypassed by women's organisations and administrative structures committed to the improvement of women's condition:***

Unfortunately, a matter so vital to public health; of such social importance; and, critical to women's rights and well-being has failed to register on the general public consciousness. Equally, it has been by-passed by women's organisations and the administrative structures committed to the improvement of women's development and health conditions.

- ***Abortion law initially reformed on fairly liberal lines for the time, but its twin thrusts of liberalisation of the grounds and medicalisation of the process of abortion have proved dichotomous:***

The overview, in its first section, brings together the historical facts of the state's *suo moto* reform of abortion law, on fairly liberal lines for the then prevailing times. It focuses on the steps taken to build a political consensus; as also, the logic leading to the twin objectives eventually enshrined in the MTP Act. This, at once, liberalised the grounds on which pregnancy termination could be possible for the woman in need and stringently medicalised the process; as also, laid the basis for a subsequent heavy bureaucratisation of recording and reporting procedures.

- ***Medical bias of the MTP Act supersedes women's interest:***

The review indicates that while the intents were most laudable, the twin thrusts have proved dichotomous within the context of the prevailing health delivery patterns. The strong medical bias of the MTP Act has eventually served to supersede women's real interests, making this a critical factor of the "collosal gap". This has also become a cause for considering the legislation to be less socially purposive than claimed.

- ***MTP Act once pioneering and radical, but now overtaken by more progressive legislation in at least 22 countries:***

The second section of the study is its more relevant part. It presents the current status. Placing the MTP Act within the global context, it is observed that

the enactment once considered globally pioneering and a fairly radical legal statement has been overtaken by far more progressive legislation. In at least 22 countries, comprising 41 percent of the world population, women now have the legal right to terminate a pregnancy, until varying gestation periods, on request.

- ***Updating of earlier abortion estimates within current demographic parameters gives an estimate of 11.2 million abortions annually : 6.7 milion induced and 4.5 million spontaneous; and, an Abortion Rate of 452:100 live births:***

The analysis of available information, both from international assessments and in-country studies and estimates, upholds the essential validity of the assumptions for the earlier abortion estimates made in India by the Shah Committee (as the Committee on the Legalisation of Abortion came to be popularly called).

This study has undertaken an exercise to further update those estimates, based on the same assumptions but in the light of the current population size and crude birth rates. Accordingly, the estimated figures of 11.2 million annual abortions, comprising of 6.7 million induced and 4.5 million spontaneous abortions are arrived at in the nineties. The Abortion Rate is estimated at 452 pregnancy terminations per 1000 live births.

- ***Review of MTP performance and number of approved institutions shows no corresponding increase; performance has stagnated around half a million since early eighties, while approved institutions have increased substantially average efficiency, always low, has further diminished over the years:***

A further analysis of MTP services and performance highlights a stagnation of MTP service utilisation around half a million for nearly a decade since the early eighties. Although the number of approved institutions for carrying out MTPs has gone up from over 4,100 to over 7,100 during the same period. The study underlines the already low efficiency of the MTP services further diminishing over the years - from an average of 120 MTPs per institution in the early eighties to 85 in 1990-91. (However, a slight increase in efficiency of performance with numbers crossing 0.6 million and the average perking to 80 per institution is noted in 1991-92, when there has been considerable Central Government follow-up.)

- ***On an average 1 MTP in 3 working days in an approved institution against earlier anticipation of 3-4 MTPs per part working day:***

On an average 1 MTP is noted to be performed in 3 working days in an

approved institution, as compared to expert projections which had anticipated a minimum of 3-4 MTPs per trained physician working part time in an approved centre. This highlights the enormous slack in the system.

- ***Significant regional variations in MTP performance and MTP facilities but no correlations noted between performance share and approved centres or with population needs:***

Significant regional variations are also noted in MTP performance. Strikingly, a state's MTP performance is not necessarily correlated with the state's share of approved centres for MTP. Nor, in turn, is the availability of these approved centres for MTP correlated to population size and likely demand/need.

Irrational differentials in facilities are observed. For instance, Mizoram has one approved institution catering to 4200 couples on an average, but Meghalaya averages 243,000 couples per approved institution.

Further, as the study observes, Uttar Pradesh, Maharashtra and Tamil Nadu together account for nearly 45 percent of the MTP performance in India, while the share of these three states in thhe country's population is around a third. Maharashtra, with less than ten percent of the population, has 22.7 percent of the approved centres; while, Uttar Pradesh with more than 16 percent of the population has only 6 percent of the approved centres; or, in other words, with 75 percent *more* population Uttar Pradesh has 70 percent *less* centres than Maharashtra.

However, Uttar Pradesh averages 225 MTPs per approved institution as against Maharashtra's average of 70. Despite this paradoxically higher efficiency, Uttar Pradesh institutions are still handling only 1 MTP per working day when there are a likely million plus abortions a year in the state.

- ***Inter-state imblance further skewed intra-state; most MTP facilities urban; only 1,800 out of over 20,000 PHCS providing MTP services:***

The highly skewed balance between the states is observed to be further skewed within the state, with MTP approved institution locations predominating in urban areas. Rural facilities remain minimal with less than 1800 of the over 20,000 PHCs in the country reported to be providing MTP services. Still more vexing, there are studies showing that the placement of a trained physician is not necessarily matched with a facility having the requisite MTP equipment. Thus, an even lower number of PHCs is actually likely to be functioning in this area of work.

- ***Key findings from MTP data on MTP client age and gestation profile and motivation for MTP and contraception:***

Salient facts, brought out by the study's analysis of the MTP data available at the Centre for the five year period 1986-91 are:

- ***Age:***

More than 80 percent of MTP seekers belong to the age group 20-34. The percentage of older women is 10-16 percent, and of teenagers 6-9 percent. However, a substantial segment is without age data available, which could point to higher teenage MTP incidence than being recorded.

Further, the share of the below 15 years old has increased, albeit marginally.

- ***Gestation:***

On an average four fifths of terminations take place in the first trimester. But since 1989 there is a significant decline in first trimester cases, which have reduced to the level of three quarters in 1991.

- ***Reasons for abortion:***

Two-fifths of women needing MTP do so because of contraceptive failure. Nearly 40 percent admit to severe physical and mental trauma caused by the unwanted pregnancy.

- ***Post abortion contraception:***

However, the share of those accepting an effective contraceptive method - terminal or IUD - is less than a half.

The proportion of those *not* accepting contraception is increasing in the 90s to nearly 55 percent, highlighting the need for more effective and caring post-abortion contraceptive counselling and services than available presently.

- ***Twice as many MTPs likely to be conducted as reported; default in reporting considerable and linked to cumbersome procedures, as also monetary gains:***

Default in due reporting of MTP procedures by approved institutions is assessed to be considerable. The study estimates at least twice as many MTPs being conducted by qualified physicians in recognised facilities as are being actually reported.

The study details the rules and regulations relating to the recording and reporting procedures and the process for licensing of physicians and institutions for the conduct of MTPs. A scrutiny of these makes the reasons for

considerable default in record keeping and reporting self-axiomatic. Equally, its contribution as a key deterrent to wider willingness on the part of medical practitioners to register - even when qualifications and experience exists, alongside the means to organise needed facilities. The rules and regulations are also observed to deter clients, besides leading to the considerable underreporting of services, even when these have been genuinely provided. However, illict monetary gain practices - through non-permitted private practice by public facility physicians and tax evasion by private physicians are also reasons for considerable under reporting by physicians.

- ***Client preference for qualified physicians and approved institutions, but poor awareness, poor accessibility and poor treatment by public health staff strong push factors toward private sector:***

A clear trend of client preference for qualified phyicians and approved institutions is seen to exist from several studies examining these issues. But poor knowledge of available MTP facilities and poor accessibility to them, besides general dissatisfaction with the services, principally because of lack of privacy, courtesy, compassionate interaction and care by public doctors/health staff, push clients into the private sector.

The private sector, as observed by this study, constitutes an amalgam of legal, medical services; medically safe but illegal services (due to failure to seek licensing to carry out the procedures and/or fulfilling legal requirements of recording and reporting procedures); and, illegal and unsafe abortions.

- ***Private sector physicians play a notable role, but non-profit NGOs still on the margin, although three NGO networks/centre merit special attention:***

Governmental efforts to promote non-governmental channels in participating in the provision of MTP services delivery is found to be rather limited, even perfunctory. While profit-motivated private sector physicans play a notable role, much of which goes unrecorded/unreported, non-profit NGO activities are yet on the margin. However, there are two major networks and one metropolitan organisation - the Parivar Seva Sanstha (PSS), the Family Planning Association of India (FPAI) and the Bombay-based Health Promotion Society (HPS) - identified as meriting particular attention and a profile of their MTP activities is detailed. It is of interest that PSS accounted for nearly 50,000 MTPs in 1992 and HPS has averaged 45 percent of Bombay's total MTPs for several years. The FPAI is, however, observed to be giving a lower priority to MTP services.

- ***Private sector contribution to pregnancy termination, including menstrual regulation (MR) estimated at 1.5 to 2.5 million:***

This study estimates the contribution of private sector doctors to pregnancy terminations to be quite considerable. According to one indication alone: the sales figures of MR kits, (used for early first trimester terminations, which almost wholly go to the private sector, since no financial provisions exist for public sector supplies) about 1.25 million to 2 million MRs are likely to be taking place, mostly through small doctor-shops. It is estimated that about a quarter to half million MTPs through other procedures could also be happening through qualified doctors with adequate facilities.

- ***Unauthorised providers predominate; amongst them dais are the leading category, followed by female paramedics:***

But at the same time, unauthorised providers of abortion services are noted, from a survey of several studies, to be still predominant. Indigenous providers outstrip qualified medical practitioners, private and public sector combined. While differences are noted in the degree and levels of unsafety in illegal abortions by unauthorised providers across the country, the phenomenon itself is seen to be widespread. Dais, trained and untrained, are the largest single category amongst unauthorised providers; female parademical workers constitute another large segment There is a marked trend of preference for female providers within the illegal provision of services, although the proportion of males amongst literate, unauthorised providers is also significant.

- ***ICMR in-depth study documents unauthorised providers use range of methods, many highly dangerous; but enjoy greater personal confidence of the client, particularly in remote areas lacking MTP facilities:***

The methods used by the unauthorised/illegal providers range widely from modern surgical and oral techniques to herbal remedies, massages of all types and vaginal insertions of foreign bodies, twigs etc. An ICMR in depth study has documeted hair raising practices, whilst pointing out that women turn perforce to those near them and with whom they have a personal rapport; most particualarly so, in the absence of physically and culturally accessible MTP services being made available and known to them.

- ***Grounding of MTP services has suffered from over-tight bureaucratic controls and under-resourcing; the later at earlier stages the consequence of dependence on the state health sector, but also later from allocations within a truncated MCH programme in the seventh plan:***

This study's examination of past efforts to ground MTP services shows that the problems in this have stemmed in considerable part from unnecessarily tight bureaucratic controls regarding training, licensing, recording and reporting procedures, coupled with acute resource constraints in developing facilities. Initially, governmental role in identifying and training/licensing qualified medical practitioners and approving institutions tended to be reactive and restrictive, rather than proactive and promotive. Alongside this, the positioning of MTP services for financial back up from the chronically resource starved state health sector was a serious policy mistake. Later, during and after the Seventh Plan - when there appears to have been renewed consciousness on the impact of unsafe abortion on maternal health and mortality - the provision of central allocations was made. But it remained limited and apportioned from within a trunacted outlay for the larger MCH effort itself. Consequently, it lacked priority in bureaucratic attention.

- ***GOI scheme for expansion of MTP services provides a three pronged strategy: MTP cell at state HQ; training of doctors in MTP techniques and supply of suction equipment; but even this limited perspective has failed to be implemented because of lack of funds and leadership; as also, inflexibility of approach and vertical thrust:***

GOI's scheme for expansion of MTP services, formulated in 1986-87 and continuing to date, provides a three pronged strategy: the creation of a MTP Cell at the State HQ, where MTPs exceed 10,000; the training of doctors in MTP techniques; and, supply of MTP suction apparatus. This review criticises the limited perspective of the MTP programme approach. It finds even more ironic the fact that even this limited perspective has failed to get off the ground because of bureaucratic apathy and confusion. This is noted as ranging from non-disbursement of funds, lack of monitoring mechanisms and effective nodal points within the administration to paltry allocations and rigid guidelines that have failed to evoke state and field response.

- ***Training and monitoring mechanisms suffer from nominal allocations and training furthermore from the limited number of training institutions and workload in these:***

While the level of funding for the creation of MTP Cells at the State Level- Rs. 1 per MTP - is observed to have reduced this to a tokenism, the training of doctors in MTP techniques has similarly suffered from low funding levels. Further, only 162 MTP training designated institutions exist across the country, being limited to the A type Post Partum Centres conducting more than 3000

obstetrics/abortion cases a year and performing more than 500 abortions a year. Thus eliminated are the over 1000 Post Partum Centres at the sub-district level that would be nearer the participants' place of residence and work and so more welcome, in view of the limited TA/DA arrangements. No special provision exists for training programmes for the private sector, or in the private sector.

There is widespread disenchantment noted with the implementation of the public sector training which is exclusively centred on practical experience, but circumscribed by the lack of sufficient cases.

- ***Enormous gap in availability and requirement of providers of MTP services; another 18,000 physicians projected for training in Eighth Plan:***

An enormous gap exists in the availability of trained physicians at the PHC level. The study highlights the need for more innovative thinking, if the Eighth Plan target of training another 18,000 physicians is to be met in a couple of years. But also questions the wisdom of merely planning on such linear expansion excercises, considering the known experience of clients with the physicians at public facilities; as also, their widespread preference for female health paramedical staff and dais, particularly in remote, rural areas.

- ***Lack of review of potential of alternative delivery channels for MTP services, even though demonstrated successful in neighbourood countries:***

A key issue in this context is that the MTP Act restricts the provision of MTP services to registered medical practitioners with requisite qualifications or who have undergone special training in MTP techniques, criminalising the process when under taken by any other, even in a dire emergency. It is well recognised that violation of this aspect occurs on a very sizable scale. But there has been absolutely no attempt to examine either policies or the experience of other countries. Several countries have demonstrated increased safe accessibility to MTP services for women in the early first trimester through *trained* paramedics permitted to perform MR, so as to channelise illegal unsafe abortion services into properly trained hands.

- ***Considerable confusion and lag in ensuring implementation of policy decisions in eighties for switchover to suction curettage techniques; no efforts to promote similiar switchover in private sector:***

Another vital issue is that despite the emphasis on the change over to the safer suction curettage techniques - from the widely practised surgical curettage practices—and the consistent allocation of funds for providing equipment for the same, public sector equipment replacement/expansion efforts have been severely hampered by both financial constraints and modalities. No effort has been made to devise a scheme to promote private sector physicians to change over to suction currettage.

- ***MTP equipment supplies gap due to changes in standard specifications for MTP equipment which have not been effectively followed through to ensure corresponding availability of equipment of requisite standards:***

Further, an expert technical review in recent years has led to a change in the BIS technical standards for MTP equipment manufacture. Manufacture has yet to be properly standardised to these required specifications, creating a supplies gap. Further, no decisions have been taken on import of equipment through WHO funds. The disinclination of certain bilateral and multilateral funding organisations to touch MTP programme strengthening adds to the difficulties. There is no provision for funds for MR equipment supplies in the Public Sector.

- ***No major review of problems leading to any attempt for substantive improvements in a decade and more; recent review mere tinkering that wil not do:***

Notwithstanding common knowledge of the considerable gap between the bureaucratic vision and the ground realities, no serious review culminating in substantive change has occured in a decade and a half. Even a recent review by the Centre has not been able to make any substantive suggestions, beyond proposing the involvement of a gynaecologist in second trimester abortions and decentralised licensing at district level through the constitution of a medical team for the purpose.

- ***Sex-selection based abortions agitation and RU 486 introduction issues likely to turn negative on MTP programme, unless carefully and purposefully addressed now:***

Other issues this study has identified as presently on the fringe but likely to erupt into major controversies, possibly negatively impacting the MTP programme unless carefully addressed ahead, are: the sex selection issue and the introduction of new medical technology such as the RU 486 pills for self-

administration for pregnancy termination. This study has attempted to summarise the conflicting standpoints even within feminist perspectives with regard to sex selection tests and raised a caution on emotive terminology and approaches that while debarring foeticide could become threatening to the adult woman's more fundamental right to her person and abortion per se.

It has also drawn attention to the conflicting assessments of the RU 486's use within the Indian context, drawing particular attention to feminist concerns about the misuse and lack of follow up on an OTC drug, given the present state of India's health delivery systems.

- ***This study attempts a comprehensive view of the current reality to enable identification of needed policy changes and the specific aspects on which focussed research is yet required:***

In sum, what has been attempted through a synthesis of the findings of existing studies, examination of MTP data at the Centre and selected states, supplemented by personal discussions of the authors is a comprehensive assessment of the prevailing situation that can provide leads for policy changes, as also for further in-depth research on particular aspects.

- ***The overall conclusion is that the MTP programme is in a dismal state and needs critical attention for streamlining of the service delivery; but more critically still, must acquire a vision beyond a "supplies and techniques" scheme:***

The overall conclusion that has emerged from such a survey is that the current situation is most dismal indeed and needs to be recognised as such. Further, that a mere linear expansion of earlier approaches:: increase in the number of recognised institutions, trained physicians and equipment supplies, will not do. The vision for MTP services must extend far beyond a "suction equipment supply and techniques training scheme", which is all that the MTP programme has ever attempted to be so far, unsuccessfully.

Agenda for Future Action - Main Recommendations:

Beyond the analysis, what action? This study makes a call for:

- First and foremost, the women's movement to take cognizance of one of the most critical issues to women's survival, rights and well being. Its active involvement is needed in the formulation and implementation of a new, more progressive women-sensitive approach in the MTP legislation and programme;

- Consideration of the need for a thorough reexamination and reframing of the MTP Act and its accompanying Rules and Regulations to remove bureaucratic and medical biases and bring about a consistent and coherent concern for women's *needs* to the fore; this should consider *inter-alia*:
- Removal of the blanket idemnity available to doctors for procedures carried out under the Act, making them liable for default or neglect, as for any other surgical procedure;
- Ensure women the right in life-threatening circumstances to emergency relief from any quarter from which it is available at the time;
- Give to the pregnant woman - and not to the doctor - the overriding decision making power, at least, in the first trimester;
- Permit widening of the net of providers who can be *trained* to deliver MTP services in the *early* first trimester, to include all those categories that are competent to help a woman deliver a child: such as, qualified medical practitioners of the Indian system already permitted to do sterilisations and to conduct deliveries; LHVs and ANMs and trained dais, particularly in remote areas where physicians are not to be regularly found, so that alternative delivery channels are created;
- Provide for differential requirements for facilities, training, equipment, the qualification of providers, between the two stages of gestation, of the termination procedures. So that, facilities and other support for first trimester are *widely and very easily* available and women are increasingly propelled to seek relief at the earliest stage.
- Second trimester termination should be well publicised, to women and providers alike, as being more hazardous and therefore requiring more stringent medical backing to ensure maximum safety.
- Clarification of legal aspects of potential conflict issues (between different aspects of women's rights and women's rights versus societal good) through a coherent set of guiding principles. These should establish the pre-eminence of the woman's absolute right to bodily integrity and personal choice, but also spell out detailed requirements to be fulfilled and procedures to be followed when exceptional circumstances arise, militating elsewise;
- Ensure extensive investment in educational and counselling efforts to widen family life education, including sex education focussed on building an ethos

of sexual responsibility for *both* the sexes as an essential part of sex-education efforts;

- Build up sensitive post-abortion contraceptive counselling and services that are culturally and psychologically acceptable to women and help women seeking MTP (and their partners) make appropriate contraceptive choices;
- Mount public education campaigns, carefully designed to build awareness of MTP services, locations, safety issues, that do not violate traditional cultural values; and alongside promote awareness of the dangers of early and frequent pregnancies, the ethics and consequences of irresponsible expression of sexuality; the ethical, medical and social issues surrounding sex-based abortion choices etc.
- Help create watch-dog mechanisms for the media to ensure balanced and responsible portrayal of sexuality matters, related behaviour patterns and life-styles, so that the young and vulnerable are not unduly exposed to unhealthy pressures.

Suggestions specific to the improvement of the existing MTP Programme:

- Guarantee a fair share of the MCH funds to strengthen the MTP programme;
- Ensure an equitable population and need based development of MTP facilities;
- Persuade international donor agencies to recognise the need to specifically support MTP services for women's health and birth control needs, as an integral part of the reproductive health care package and for a coordinated implementation of MCH activities;
- Development of MTP services, monitoring and coordinating mechanisms, as part and parcel of Safe Motherhood and Family Welfare activities and within the framework of MCH, so that it is developed as an integrated and not vertical thrust;
- MCH Cells to be suitably strengthened at the Centre and the States and assigned MTP specific responsibilities;
- Enhancement of the present allocations for drugs and dressings;
- Step-up of the training budget and provision in it of TA/DA to trainees and enhanced budgets to training institutions for organising appropriate training and communication aids, including for training manuals;

- Widening of the training base to include the sub-district PP centres; as also, non-governmental training channels such as the Indian Medical Association and the existing leading NGOs servicing MTP on some scale;
- Experimentation with designated OPD MTP centres within the hospital setting; earmarking of particular days for offering MTP services; encouragement of paramedical staff to assist;
- Liberalisation of the rules and regulations with separate protocols for approval of physicians and places for first trimester termination.
- Decentralisation of the process of recognition for physicians and institutions to the district level and removal of inspectorial requirements beyond routine inspections, as applicable to all other institutions providing surgical procedures;
- Relaxation of the elaborate confidential recording and reporting arrangements to bring MTP on par with other procedures for surgical interventions and the general principles and medical ethics governing such matters;
- Immediate, clear cut decisions on the various technical issues in equipment manufacture and purchase rules;
- Promotion of indigenous manufacturing capability and open dialogue with manufacturers;
- Building up of quality assurance testing facility at the IIT (Delhi), or any other suitable place, as a time-bound programme.

THE BACKDROP 1

Prior to the passage of the MTP Act in August 1971, induced abortion - although widely practised surreptitiously - was an outright criminal offence. Termination of pregnancy came under the purview of the Indian Penal Code (IPC), framed in 1860 in accordance with 19th century British law.

Under Section 312 of the IPC anyone voluntarily "causing miscarriage" to a woman with child - other than in "good faith for the purpose of saving her life" was punishable by imprisonment that could be simple or rigorous and/or a fine. Where the woman was "quick with child" the punishment for causing a miscarriage was imprisonment extending upto seven years and a fine. Furthermore, the IPC explicitly clarified that the woman causing herself to miscarry was "within meaning of the section", i.e. as culpable for the crime. Thus, both the expectant mother and the service provider were rendered as ordinary criminals, irrespective of the woman's circumstances or will. The sole exception existed only in a situation of medically indicated danger to life. However, because of this one proviso it could be considered that, in a technical sense, legal abortion existed in India even prior to the seventies.[3]

The IPC also provided for the most punitive punishment (extending upto life imprisonment) for a miscarriage caused without the pregnant woman's consent. Other sections dealt severely with death due to the procedure: upto ten years of imprisonment and fine, extending upto life imprisonment where it had been conducted without the woman's consent. To this extent, the IPC was protective of the woman's right as an individual. But other sections dealt severely with injuries to the foetus, exposure of infants and concealment of births.[4] In sum, the pre-1971 law gave unequivocal precedence to the rights of the foetus over that of the woman to her person. The woman who refused to carry the burden of her pregnancy was reduced to a criminal, no matter what her trauma or how pressing her personal circumstances. No allowance was provided even for the earliest stages of pregnancy. The sole exception being, as earlier stated, a medical emergency threatening the pregnant woman's very survival. This however, became the peg on which liberalisation of the law could proceed later.

The Ancient Indian Background

Ancient India appears to have been quite familiar with the phenomenon of abortion, pointing to women's exertion of their will - or, perhaps more

[3] United Nations (1982), *Population of India, Country Monograph Series No 10*, Escap, New York, p.885.

[4] Manekar, Kamla (1973) *Abortion, A Social Dilemma*, Vikas Publishing House, New Delhi, pp.103-

abortion, pointing to women's exertion of their will - or, perhaps more appropriately, of confronting their difficulties - even at the dawn of history. The first reference to abortion occurs in the Atharva Veda (c 2000-800 B.C.). The Brihadyogalarinigini (1st century B.C.) is said to contain several contraceptive recipes, including a method for the occlusion of the cervix.[5]

The three Sanskrit medical classics, written respectively by Susruta, Charaka and Vaghbata I, which comprise the main body of knowledge of ancient Hindu medicine, deal with abortion and miscarriage amongst other reproductive issues[6]. Susruta differentiates between "garabhapata" - spontaneous abortion - and "garabhasrava" - induced abortion, although, this is expressed only in terms of gestation period. The former is classified as that which is upto four months, when only liquid is said to flow from the womb; the latter, when the limbs of the foetus have gained firmness or it is viable.[7]

The earliest references to abortion are almost all condemnatory of the practice. But the fact that almost all ancient Hindu writers and lawgivers, including Manu, dealt with the subject - often at some length - indicates more than sporadic existence of the practice over 4000 years.[8] Abortion, on a fairly large scale, is stated to have existed during the Gupta period, the golden age of Hindu history. Even then, there were prescribed periods of gestation beyond which abortion was forbidden to be induced. The foetus had to be aborted before it gained firm shape or viability.[9]

In the 17th century work of the Acharya Lolinbaraj, a well known Ayurvedic physician of his times, the means of tackling an unwanted pregnancy is clearly provided by the sage-physician, alongside a categorisation of women who could need it: "If the root of the herb Indrayam is kept in the vagina, menstrual discharge begins. It is an useful remedy for pregnant women in poor health, widows and women of liberal morals."[10]

National Debate Prior to MTP Act

Concern about the abortion issue manifested itself in Independent India only in the mid-sixties. This was also the time when the British law was under review in the UK. The impetus came from the Central Family Planning Board

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[5] Chandrashekar, S. (1974) *Abortion in a Crowded World*, George Allen & Unwin Ltd., London, p.23.
[6] *Ibid*, p.42
[7] *Ibid*, p.43
[8] *Ibid*, p.44
[9] Manekar, *op. cit*, p.25.
[10] Chandrasekar, S. *op. cit*, p.45.

coming before the health services of large numbers of mothers - practically all married women in a society wherein marriage was near-universal and early - prepared to risk their lives, or otherwise suffer horrible consequences, rather than carry the particular pregnancy to full term. Doctors in hospitals were constantly witnessing the futile wastage of human lives, as also scarce medical skills, drugs and equipment being expended on tackling septic abortions.[12]

Accordingly, the CFPB, in its meeting of August 1964, took up the issue voicing concern on the large numbers of illegal abortions occurring in the country under insanitary conditions, affecting the health and lives of pregnant women.[13] Consequently, Government of India (GOI) set up an eleven member committee to study the question of legalisation of abortion in all its aspects - legal, medical, social and ethical - and make recommendations for the same.[14]

The Committee was chaired by Shri Shantilal Shah, the then Minister of Public Health, Law and Judiciary of the State of Maharashtra. It included 5 eminent women social workers and 4 medical doctors, with the then Director of the Central Family Planning Institute as the Member-Secretary[15] - a fact that has caused the report to be wrongly considered the product of demographic concerns.

Committee on the Legalisation of Abortion

The Shah Committee deliberated for more than 2 years. It considered a wide range of evidence - including 570 replies to a questionnaire extensively circulated by it, of which 230 were from medical persons and 140 from welfare and women's organisations.[16] It also surveyed the prevailing laws on the subject in a number of other countries. In particular, it utilised the provisions of the draft British law, then under consideration.[17]

The report, submitted to government on the eve of 1966, made a learned case for a broadening and rationalisation of the laws pertaining to abortion. The expert group had cleverly moved its terms of reference out of the issues of legalisation into liberalisation on the grounds that, technically, legal abortion was permissible under the IPC, notwithstanding the fact that this could happen on

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11 Seth, D.D. and B.N. Sinha (1973) *'Abortion and Termination Of Pregnancies In India'*, Delhi Law House, Allahabad, p.1.

12 *Report of the Committee to Study the Question of Legalisation of Abortion*, p.39.

13 Seth, et al. *op cit*, p.2

14 *Ibid*, p.2.

15 *Report of the Committee to study the question of legalisation* of Abortion, p.3.

16 *Ibid*, pp.66-67

17 *Ibid*, p.53.

only one solitary ground.[18] It was also very categorical in dismissing any expectation of abortion as a demographic tool, but ably underlined its significance as a needed and critical women's health measure. The report *inter alia* raised some pertinent women's rights issues, pointing out: "When the woman (with or without the concurrence of her partner) feels that a particular pregnancy is intolerable and does not desire to bear the child... should not (she) be the master of her own body and decide the question of motherhood for herself."[19] This argument was to provide the basis for the conceding of some radical rights to Indian women. It included one - the right to opt for termination upon the failure of contraception - accorded for the first time in the world.

Considering the environment of the era, the Shah Committee's recommendations were extremely progressive on women's behalf. However, there is no doubt that the Committee, consisting one half of doctors and the rest strongly linked with and influenced by the medical sector - approached the matter of providing these rights and the services to effect them on extremely conservative medical lines. Ironically, the members, although familiar with the health system - shaped their recommendations, visualising the possibility of a very streamlined health delivery setup.

The report proposed that a qualified medical practitioner acting in good faith should be permitted to terminate a pregnancy, not only for the sole purpose of saving a woman's life, but also wherever the pregnancy posed:

- serious risk to her life, or grave injury to her health, physical or mental, before or after the birth of the child;
- substantial risk of the possibility of a seriously physically or mentally handicapped child being born; and
- where the pregnancy resulted from rape or intercourse with a minor or a mentally retarded girl.

Beyond this, the Committee made elaborate recommendations regarding the conditions to be complied with in connection with any treatment for a termination. It made clear that authorised abortions should be performed only by a person holding qualifications granted by an authority specified or notified in any of the schedules to the Indian Medical Council Act 1956 (202) as modified upto 1st December 1964. The terminations should take place only at a duly approved place, with medical opinion certified and the consent of the women taken in writing prior to the procedure - except in exceptional

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[18] *Ibid*, p.40
[19] *Ibid*, p.41

women taken in writing prior to the procedure - except in exceptional circumstances, where the lacuna would be required to be filled thereafter. It desired Government to frame specific rules regarding record keeping and reporting, assuring confidentiality in the same.

In addition, the Committee advocated a vigorous promotion of the small family norm and contraception; also family life education on sex, marriage and parenthood, together with an expansion of easily accessible family planning services that would help minimise the incidence of pregnancy termination. To prevent repeat abortions in the case of women not fit to bear the strain of further pregnancies, it recommended the doctor to advise for voluntary sterilisation of either spouse.[20]

Medical Termination of Pregnancy Bill (Rajya Sabha) 1969

Three years elapsed before legislation, based on the Committee's recommendations was introduced in the Rajya Sabha, after all states and UTs had provided a feedback. The Bill's statement of objects and reasons pointed out that the existing strict law was being breached "... by very large numbers of cases all over the country ... most of the mothers married women ... under no necessity to conceal their pregnancy." It explained the proposed measure as being conceived in the spirit of : (i) a health measure for the woman; (ii) an humanitarian measure providing relief where a sex crime had been committed; (iii) an eugenic measure.

A Financial Memorandum attached to the bill sought support for the creation of facilities at government hospitals to meet the demand arising from the enactment. This anticipated the provision of "vacuum aspirators, increased number of beds, staff etc." It sought a recurring expenditure of Rs. 2.4 million and a non recurring expenditure of Rs. 1.93 million.[21] Considering the report had estimated at least 4 million illegal abortions taking place, the arithmetic fell short by a long haul. In the event, the Financial Memorandum simply disappeared.

The debate on the bill revealed a large measure of sympathy, but also some ignorance and hesitation about the possibility of the misuse of the law. The government, desirous of passing the measure with social consensus rather than any show of strength, referred the matter to a Select Joint Committee of both Houses of Parliament.[22]

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20 *Ibid*, pp.51-53.

21 Chandrasekar, *op cit*, p.91

22 *Ibid*, pp.88-89.

The Joint Select Committee Review

The Select Joint Committee reviewed 27 memoranda and interviewed over a score of witnesses over 2 years. The medical profession was again the most organised and vocal. Based on the evidence it gathered, the Committee introduced some major changes, besides redrafting some of the clauses. Mainly, these were:

(i) a new clause providing for Central Govt. to be responsible for framing the rules to carry out the provisions of the Act in general; and, in particular, to prescribe the experience or training that a medical practitioner should have to be authorised to perform under the Act;

(ii) a new subclause empowering the Central Govt. to appoint, by notification in the official gazette, a later date for the Act's enforcement, in order to enable the Central and State governments to finalise the rules and regulations prior to its implementation;

(iii) a subclause that made the termination of a pregnancy by a person other than a registered medical practitioner a punishable offence under the IPC Code;

(iv) amendment of the definition of a registered medical practitioner to clarify holding of requisite experience or training in obstetrics and gynaecology as essential;

(v) redefinition of the term guardian to ensure that only one caring for the person of the minor/lunatic and not one overseeing their property, be considered in this category;

(vi) deletion of a subclause requiring the written consent of the husband of a married woman seeking termination of pregnancy on grounds of alleged rape;

(vii) clarification that terminations over twelve weeks and under twenty weeks of gestation required the concurrence of two doctors, but that the procedure could be executed by a single qualified medical practitioner;

(viii) narrowing of the relaxation provided to the mandatory two doctors concurrence in second trimester termination to cover only life threatening emergency, deleting the ground of grave injury to physical or mental health;

(ix) clarification that where life is endangered termination can be carried out by a general practitioner lacking OBGYN experience.[23]

The concern to secure and protect the woman's interests is all too evident in these amendments. But they also served to further medicalise the services into a still stronger specialised straitjacket. Of particular note is the development that termination of pregnancy by other than a registered medical practitioner would be explicitly defined as illegal from now on. The IPC Code had allowed the termination of a pregnancy under life threatening circumstances without any particularisation on this score.

Media Support

Earlier, the introduction of the MTP Bill in the Rajya Sabha had resulted in a limited furore among conservative citizens, some of whom described the bill as a "chapter for licence".[24] While doctors and demographers had taken the initial initiative to focus attention on the problems arising from illegal abortions, the English language press provided commendable support at this subsequent stage. The media focussed eloquently on the deleterious health effects of illegal abortions; it also drew attention to positive demographic consequences of legalising abortion. There was an occasional rumbling on negative implications, such as fears of "encouraging profligacy" and "pleasures unlimited". But, by and large an enlightened media, an influential medical lobby and some women's voices networked purposefully to create a conducive climate.[25]

Consensus Develops

Eventually, the proposal - made in August 1964 to reexamine the century old restrictive law—ended in a quiet triumph in August 1971, a full seven years later. Considerable time had passed but a consensus had developed, albeit with some compromises. As one prime mover of the times - S. Chandrashekar, then Minister of State for Health and Family Planning - recorded: "I wanted to make the Indian law simple and grant abortion virtually on demand, because an overwhelming majority of Indian women are married early and by and large seek abortion for a high parity birth from a back street abortionist." But he admitted having failed to obtain a consensus on this point amongst his ministerial colleagues.[26]

Nevertheless, Indian women did not need to march in protest to revoke an oppressive law and gain one which was still amongst the more liberal of the

23 Chandrashekar, *op cit*, pp.101-106.

24 *The Statesman*, July, 1971.

25 Chandrashekar, *op cit*, pp. 146-60; Chhabra, Rami (1971) 'Step Towards Emancipation" *The Statesman*, July 25.

26 Chandrashekar, *op cit*, p.10.

times. At the outset of the seventies, there were only three countries where more liberal policies prevailed: Hungary, USSR and parts of USA, where within the three states of Alaska, New York and Hawaii, termination of pregnancy was permissible on the request of the woman.

India, in passing the MTP Act (1971) took its place amongst a handful of nations permitting pregnancy termination on a broad range of social and socio medico grounds.[27] It included a new pathbreaking concept - recognition that failure of a contraceptive method could cause extreme mental anguish to the woman and of her prerogative to act, unilaterally of her spouse, to resolve such a situation. Altogether, the MTP Act could be considered as constituting a landmark in India's social legislation. It was also an achievement of consensual politics. Its ultimate enactment witnessed no histrionics; no opposition was voiced as it became law.

The MTP Act (1971)

There can be no two opinions about the strong medical bias of the MTP Act. The fact is reflected in its very title; and, amply clarified in the introductory paragraph. This states it to be: "An Act to provide for the termination of certain pregnancies by registered Medical Practitioners and for matters connected therewith or incidental thereto."

Initially, this was an asset serving to soften resistance. In the longer term, this aspect has served to considerably negate the very advantages the Act sought to bestow. Legal commentaries, written shortly after the enactment, rightly pointed out its twin objectives: on the one hand, liberalisation of the grounds on which termination could be possible; and on the other, still greater stringency of the law to ensure the performance of a proper medical procedure. Thus, the Act was described as simultaneously decriminalising and medicalising the process of pregnancy termination.[28]

There is no reason to doubt that at the time, both types of steps were conceived in what, was considered the most enlightened interest of women's well-being. But its subsequent implementation has led to a questioning of both the motives and the essential wisdom of a legal framework that has remained as much breached, as the breach it was created to fill.[29]

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27 *Report of the Committee to Study the Question of Legalisation of Abortion*, p.10

28 Seth, *op cit*, p.4.

29 Karkal, Malini (1991) Abortion Laws and the Abortion Situation in India, "*Issues in Reproductive and Genetic Engineering*, Vol.4, No.3; and Gupte, Manishe "Review and Per spective" (Mimeo).

The MTP Act permits the termination of pregnancy on the following grounds:

(i) where the continuance of the pregnancy involves a risk to the life of the pregnant woman or of grave injury to her physical or mental health;

(ii) where substantial risk exists of the child being born with a serious physical or mental abnormality;

It clarifies, in two separate explanatory notes, that pregnancy following rape shall be and following failure of contraception may be presumed to constitute grave injury to mental health. While providing the woman with the option to seek a legal termination on such broad grounds, it grants a monopoly to medical opinion at two levels—in matters related to both the length and type of pregnancy. If the length is up to twelve weeks one registered medical practitioner may endorse the decision and carry out the procedure; if the length is beyond twelve weeks but under twenty weeks, two registered medical practitioners must concur, except in exceptional life threatening circumstances, for which the necessary paperwork is nevertheless required to be fulfilled subsequently. Further, the Act enjoins on the doctors to take the pregnant woman's "actual or reasonable environment" into account to determine whether the continuation of the pregnancy constitutes risk/injury to physical or mental health.

Thus, the woman is not the ultimate arbiter of what constitutes endangerment of her well-being; nor, can she escape a detailed explanation in order to secure the procedure. It is rightly pointed out by women activists that while under the present demographic and socio-economic conditions medical opinion can be relied upon for a liberal interpretation of the law, the same remains open to more restrictive assessment in a changed context.[30]

Under the Act no pregnancy can be terminated in accordance with its provisions at any place other than:

(i) a hospital established or maintained by the government; or

(ii) a place for the time being approved for this Act by the Government.

The Act defines a registered Medical Practitioner (RMP) as one possessing any recognised medical qualification as defined in Clause (h) of Section 2 of the Indian Medical Council Act 1956. The name must be enrolled on the

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30 Gupte, Manishe, *op cit*; and Karkal Malini, *op cit*.

State Medical Register. Further, the medical practitioner must have such experience or training in gynaecology as prescribed by the rules of the Act. It is incumbent upon the RMP to observe the rules framed by the Central Govt. with regard to this Act, as also other regulations as laid down by the concerned State Govt. The rules framed by the Central Govt. are required to be laid, for a period of 30 days, before both Houses of Parliament for their approval, immediately after framing or as soon as the Parliament enters into session, as the case may be.

The Act indemnifies against all criminal, legal or any other action a registered medical practitioner terminating a pregnancy in observance of the conditions, rules and regulations of the Act. Furthermore, it absolves the registered medical practitioner of breaching any or all of the stipulations in a case, where an opinion has been formed in good faith, that immediate intervention is necessary to save the pregnant woman's life.

At the same time, the Act is equally explicit in not condoning any termination of a pregnancy, notwithstanding the circumstances, conducted by a person who is not a medical practitioner. This is now deemed an offence under the IPC, which stands modified on this account. Earlier the IPC had not made a specific distinction between medical and non medical personnel when it came to life threatening circumstances.[31]

Thus, it may be observed that these conditions, while created to provide safeguards for women, have instituted two major legal restrictions to the accessibility of MTP services: (i) It can only be performed by a medical practitioner meeting the stipulated training and experience requirements in gynaecology; and (ii) At a place which has been sanctioned by an appropriate authority as meeting the required standards and facilities prescribed for securing such permission.[32] On the other hand, the MTP Act provides a full shield to the doctor acting in accordance with its provisions.

MTP Rules and Regulations

The Central Govt. has laid out a very elaborate set of rules and regulations governing the MTP Act. These are further supplemented by the States. First framed in 1972, when a number of boards were set up to screen applications for recognition of medical practitioners and institutions, the MTP Rules were substantially amended in 1975. Training and experience requirements were

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[31] *MTP Act, 1971.*

[32] Gupte, Manishe, *op cit.*

somewhat reduced in the light of practical experience. Further modifications were made in 1977 - basically the removal of the CMO's power to call for information or seize documents or other items (as per under the Code of Criminal Procedure) on suspicion of a death, injury or other malpractice.[33] These rules are further discussed in the subsequent section. (Appendix I for MTP Act, 1971 and Appendix II for MTP Rules and Regulations)

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33 Govt. of India, *Gazette of India*, Part II, Section 3, Subsection (I), pp.2908-15.

THE PRESENT STATUS

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India's law relating to abortion—the MTP Act—places its on middle ground in today's world context of women's rights and legal access to end an unwanted pregnancy. India is among 13 countries, comprising 22 per cent of the world population, where termination of pregnancy is possible on broad social and socio-medical grounds. (Table 1).

However, in another 22 countries comprising 41 per cent of the global population—which include USA, Canada, practically the whole of Europe, countries of the former Soviet Union, Cuba, China, plus several other Asian countries such as Mongolia, Singapore, Turkey, Vietnam—women have the legal right to terminate a pregnancy, upto varying gestation periods, on request. At the same time, there remain as many as 94 countries, comprising 37 per cent of the global population, with restrictive laws that range from strict to very strict, including some countries where abortion is prohibited without exception. The majority of the countries imposing restrictions are in Africa and Latin America, but also some in Europe and Asia.[34] (See Map)

But despite two decades of legal pregnancy termination under liberalised circumstances, the abortion issue has not really emerged out of its wraps in India. The figures regularly reported under the MTP Act and published, are well known to be the mere tip of the iceberg. Few countries across the world have statistics believed to be reasonably complete[35]. Therefore, India is not an exceptional defaulter in this regard. However, the extent of the gap between legally reported terminations and the likely actual incidence is perhaps exceptionally large; more so, when viewed in terms of absolute numbers.

Estimates of Abortion Prevalence

Overall Magnitude

One global estimate[36] considers India's official figures (currently in the range of 0.6 million) to be underreporting even legally carried out abortions by at least 20 per cent. It places India's legal abortion rate somewhere between 2 to 5 times the reported rate of 3 abortions per 1000 women. Furthermore, it notes 15 million illegal abortions for which estimates are available from various studies. About 4 million are contributed by India alone. This is the highest figure

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34 Planned Parenthood Challenges (1993), Unsafe abortion, 1; pp.27-28

35 Tietze, C, (1981) *Induced Abortion: A World Review*, A Population Council Fact Book; p.10.

36 Henshaw, Stanley K., *op cit*, pp.151-153

Table 1
Restrictiveness of Abortion Law in Different Countries

Law	*Africa*	*Asia & Oceania*	*Europe*	*North America*	*South America*
To save a woman's live	Angola Benin Botswana Burkina Faso Central Afr. Rep. Chad Cote d'voire Gabon Libya Madagscar Malawi Mali Maunitania Mauritius Mozambique Niger Nigeria Senegal Somalia Sudan Zaire	Afghanistan Bangladesh Burma Indonesia Iran Iraq Laos Lebanon Oman Pakistan Philippines Sri Lanka Syriya UnitedArab Emirates Yemen Arab Rep. Yemen, Peoples Democratice Rep.	Belgium Ireland	Dominican Rep. El Salvador*.! Guatemala Haiti Honduras Mexico* Nicaragua Panama	Brazil* Chile Colombia Ecuador* Paraguay Venezuela
Other maternal health reasons	Algeria Cameroon*! Congo Egypt! Ethiopia Ghana*,! Guinea Kenya Lesotho Liberia*,! Morocco	Hong Kong*,! Israel*,! Jorden* Korea, Rep. of*.! Kuwait! Malaysia*,! Mongolia Nepal New Zealand*! Papua New Guinea Saudi Arabia	Albania Northen Ireland portugal*,! Spain*,! Switzerland	Costa Rica Jamaica Trinidad & Tobago	Argentina* Bolivia* Guyana Peru

Law	*Africa*	*Asia & Oceanina*	*Europe*	*North America*	*South America*
	Namibia*! Rwanda Sierra Leone South Africa*,! Tanzania Uganda Zimbabwe*,!	Thailand*			
Social and social-medical reasons	Burundi Zambia!	Australia! India**,!! Japan*, !$$ Korea, Dem. Rep.*,! Taiwan*,!	Bulgaria*, !, & Finland*, !, &&& German Fed Rep.*, ! &&,*, Great Britain! Hungary*,!,&& Poland*, $$,&&		Uruguay*, $
On request	Togo Tunisia&&	China Singapore Turkey$$ Vietnam	Austria!!,*! Czechoslovakia&& Denmark&& France$$ German Dem. Rep. && Greece && Italy && Netherlands Norway&& Romania&& Soviet Union&& Sweden*& Yugoslavia!!	Canada Cuba&& Puerto Rico United States	

* Includes juridical grounds, such as rape and incest.
! Includes abortion for genetic defects.
& Approval is automatic for women who meet certain age, marital and/or parity requirements.
$ Not permitted for health reasons but may be permitted for serious economic difficulty.
** During the first 20 weeks.
!! During the first 10 weeks.
&& During the first three months
g., Bhutan and Kampuchea). All abortions are permitted only prior to fetal viability unless otherwise indicated in footnoes.
*++ During the first 18 weeks.
Notes : Table does not include countries with fewer than one million inhabitants or those for which information on the legar status of abortion could not be located (e.g. Bhutan and Kampuchea). All abortions are permitted only prior to fetal viability unless otherwise indicated in footnotes.
Source: Henshaw, Stanley K. (1990) "Induced Abortion: A World Review, 1990", Family Planning Perspectives, 22 (2).

WORLD
ABORTION LAWS

Source: *Induced Abortion: A World Review* (1990 Supplement). Alan Guttmacher Institute, New York, 1990. Updated by personal communications, 1995.

EUROPE

Albania	21	Italy	25
Austria	23	Netherlands	12
Belgium	11	Norway	2
Bulgaria	19	Northern Ireland	6
Czech. Rep.	16	Poland	15
Denmark	13	Portugal	8
Finland	4	Romania	18
France	10	USSR (former)	26
Germany	14	Spain	9
Great Britain	7	Sweden	3
Greece	20	Switzerland	24
Hungary	17	Yugoslavia (former)	22
Iceland	1		
Ireland	5		

THE AMERICAS

Argentina	131	Honduras	112
Bolivia	128	Jamaica	117
Brazil	127	Mexico	109
Canada	107	Nicaragua	113
Chile	130	Panama	115
Colombia	122	Paraguay	129
Costa Rica	114	Peru	126
Cuba	116	Puerto Rico	120
Dominican Rep.	119	Trinidad & Tob.	121
Ecuador	125	United States	108
El Salvador	111	Uruguay	132
Guatemala	110	Venezuela	123
Guyana	124		
Haiti	118		

AFRICA

Algeria	78	Guinea	40	Rwanda	54
Angola	59	Kenya	57	Senegal	39
Benin	47	Lesotho	61	Sierra Leone	41
Botswana	63	Liberia	42	Somalia	58
Burkina Faso	64	Libya	80	South Africa	66
Burundi	55	Madagascar	68	Sudan	56
Cameroon	49	Malawi	61	Tanzania	58
Cent. Afr. Rep.	50	Mali	53	Togo	46
Chad	35	Mauritania	32	Tunisia	79
Congo	52	Mauritius	69	Uganda	56
Cote d'Ivoire	43	Morocco	77	Zaire	53
Egypt	81	Mozambique	65	Zambia	60
Ethiopia	37	Namibia	62	Zimbabwe	64
Gabon	51	Niger	34		
Ghana	45	Nigeria	48		

ASIA & OCEANIA

Afghanistan	82	Korea, Rep. of	98	Singapore	101
Australia	95	Kuwait	76	Sri Lanka	89
Bangladesh	87	Laos	93	Syria	71
Cambodia	92	Lebanon	72	Taiwan	96
China	89	Malaysia	100	Thailand	91
Hong Kong	95	Mongolia	88	Turkey	70
India	84	Myanmar (Burma)	90	UAE	80
Indonesia	103	Nepal	86	Vietnam	94
Iran	81	New Zealand	106	Yemen	78
Iraq	75	Oman	79		
Israel	73	Pakistan	83		
Japan	99	Papua N. Guinea	104		
Jordan	74	Philippines	102		
Korea, Dem. Rep.	97	Saudi Arabia	77		

for any single country. The analysis, pointing out the approximate nature of all abortion estimates, places the clandestine world abortion figures within a range of a low of 10 million to a high of 22 million, within an overall global total of 35-53 million a year. The actual situation in India is the single most critical determinant of the global magnitude of unsafe illegal abortion.

Earlier Estimates

The Shah Committee (1966) had estimated an annual incidence of 6.5 million abortions, indicating three-fifths or 3.9 million to be induced and two-fifths or 2.6 million to be spontaneous. The Shah Committee's estimates were based on: (i) the then population size of 500 million and prevailing CBR of 39:1000 population; and (ii) the assumption that for every 73 lives births there are 2 still births and 25 abortions, of the latter 15 induced and 10 spontaneous.[37]

The assumptions on conception outcomes were based on studies done in the community by Gandhigram, Tamil Nadu and separately supported by Delhi hospital based data documenting 1 abortion case for every 3 deliveries in the maternity wards of 2 major hospitals in the capital city.[38] Other small hospital based studies carried out over the 50s and 60s varied from 4-30 per cent.[39]

Any criticism that these original estimates are exaggerated on account of being extrapolated from small studies is belied by:

(i) The figures, since inception, of the Post Partum Programme covering 534 institutions, which consistently show the percentage of abortion cases to obstetric cases as around 1:4;[40]

(ii) Their close correspondence to other international studies/ assessments of global incidence. For instance, IPFF's 1974 estimate of 55 million world wide abortions was premised on an abortion ratio of 300:1000 known pregnancies and an abortion rate of 70:1000 women in the reproductive age groups.[41] More recent global estimates, considered the most reliable presently available, place worldwide induced abortions between 36-53 million and indicate that

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37 *Report of the Committee to Study the Question of Legalisation of Abortion*, pp.17-18.

38 *Ibid.*

39 Rao, Kamla Gopal, *Studies in Family Planning in India*, Abhinav Pub. New Delhi, pp.380-392.

40 Govt. of India (1991). *All India Hospitals. Post Partum Programme. Annual Report*, 89-90, MOHFW, p.42.

41 Tietze, C. *op cit* p.19.

roughly one quarter of all pregnancies world wide are being deliberately terminated.[42]

IPPF, in 1970, had estimated 6.5 million illegal abortions in India, corresponding to an abortion ratio of about 200:1000 known pregnancies and an abortion rate in the vicinity of 55:1000 women aged 15-44 years. As against this the reported rate of legal abortion at the end of the seventies decade was noted to be a mere 2.3:1000 women aged 15-44 years and an abortion rate of about 12:1000 known pregnancies.[43]

Other estimates and surveys have similarly highlighted enormous differences between the figures captured in the legal stream and the true incidence of abortions in India. Goyal (1976) estimated 4-6 million illegal abortions. Malini Karkal (1991) estimated 3 illegal abortions to every legal one in the rural areas and a still higher ratio of 4-5 illegal abortions : 1 pregnancy termination in the urban areas.

More conservative have been the findings of an ICMR Task Force (1989).[44] The ICMR conducted a multicentric 5 state study on illegal abortion over 1983-85, covering 11,887 women reporting on their total pregnancies. It captured 19.4 abortions: 1000 known pregnancies. However, this study found the illegal abortion to be 2.2 times that of legal medical termination. Further, it found a ''surprisingly high'' level of spontaneous abortions - an average of 42:1000 pregnancies, so that overall abortion incidence reached 61.4 : 1000 pregnancies. There were also marked interstate differentials - ranging from a low of 3.8 induced abortions in Rajasthan to a high of 46.6 in Orissa. Besides, as researchers have observed in other contexts, induced abortions tend to be under reported even in communities where the practice is widely accepted.[45]

Several researchers reviewing the literature have assessed all existing studies to be considerable underestimates. One recent estimate suggests a figure of 8 illegal abortions to every legal one taking place.[46]

Update of Earlier Estimates

Therefore, in order to get a handle on the size and scope of the task for improved abortion services, we have attempted in this paper an update

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42 Planned Parenthood Challenges, *op cit*, p.28.
43 Tietze, C. *op cit.*, p.25.
44 ICMR (1989) *Illegal Abortion in Rural Areas*, New Delhi
45 Henshaw, Stanley K., *op cit*, p.79.
46 Gupte, Manishe, *op cit.*

of the Shah Committee's estimates in the present demographic circumstances.

The number of estimated abortions based on the Shah Committee assumptions but corrected for changed population size and birth rates, as prevailing in 1991, are presented in Table2.[47]

Table 2
Estimated Number of Abortions

Sl. No.	States/UTs	Total Abortions. 1991 (000)	Induced Abortions, 1991 (000)	Abortions per 1000 Couples, 1991	Induced Abortions per 1000 Couples, 1991
1.	Andhra Pradesh	887	532.2	74	44.4
2.	Arunachal Pradesh	11	6.6	86	51.6
3.	Assam	299	179.4	91	54.6
4.	Bihar	1152	691.2	73	43.8
5.	Goa	15	9.0	93	55.8
6.	Gujarat	551	330.6	80	48.0
7.	Haryana	220	132.0	82	49.2
8.	Himachal Pradesh	69	41.4	80	48.0
9.	Jammu & Kashmir	NA	NA	NA	NA
10.	Karnataka	600	360.0	82	49.2
11.	Kerala	388	232.8	91	54.6
12.	Madhya Pradesh	883	529.8	76	45.6
13.	Maharashtra	1052	631.2	79	47.4
14.	Manipur	24	14.4	103	61.8
15.	Meghalaya	24	14.4	92	55.2

[47] The number of abortions has been estimated on the basis of the following:
i) Number of births in each year have been calculated by taking the birth rate for 1990-91 and population of Census of India, 1991.
ii) Number of abortions have been worked out on the basis of 25 abortions per 73 live births
iii) Number of abortions estimated above have been adjusted for existing birth rate by multiplying the number of abortion by the factor of birth rate of 39/existing birth rates in States/UTs.
iv) Number of induced abortions has been estimated on the basis of the assumption that of the total abortions, three-fifths are induced and two-fifths are spontaneous.

Sl. No.	States/UTs	Total Abortions. 1991 (000)	Induced Abortions, 1991 (000)	Abortions per 1000 Couples, 1991	Induced Abortions per 1000 Couples, 1991
16.	Mizoram	NA	NA	NA	NA
17.	Nagaland	16	9.6	112	67.2
18.	Orissa	422	253.2	81	48.6
19.	Punjab	270	162.0	91	54.6
20.	Rajasthan	587	352.2	77	46.2
21.	Sikkim	5	3.0	94	56.4
22.	Tamil Nadu	745	447.0	79	47.4
23.	Tripura	37	22.2	89	53.4
24.	Uttar Pradesh	1855	1113.0	78	46.8
25.	West Bengal	908	544.8	83	49.8
26.	A & N Islands	4	2.4	84	50.4
27.	Chandigarh	8	4.8	79	47.4
28.	Dadra & Ngr.Haveli	2	1.2	76	45.6
29.	Daman & Diu	1	0.6	93	55.8
30.	Delhi	125	75	82	49.2
31.	Lakshadweep	1	0.6	81	48.6
31.	Pondicherry	11	6.6	85	51.0
	INDIA	**11185***	**6711***	**78***	**46.8***

* Excluding Jammu and Kashmir

It may be seen that, as of 1991, the likely annual number of abortions in the country is over 11.2 million, counting both induced and spontaneous abortions. Induced abortions may be expected to be 6.7 million.

Further, it is important to remember that many of the 4.5 million spontaneous abortions will also require some health care and attention. (Over 1988-90, the Post Partum programme treated 1 spontaneous abortion case for every 2.5 to 3 MTPs carried out.)

Table 2 shows that the highest number of estimated abortions are to be expected in Uttar Pradesh - over 1 million induced abortions a year, followed by Bihar, Maharashtra, West Bengal, Andhra Pradesh, Madhya Pradesh,

Tamil Nadu and Karnataka in that order. In order to have a better appreciation of the abortion prevalence, the number of abortions per 1000 couples in the reproductive age group has also been worked out (Table 2).

For instance, in some of the states, the birth rate has fallen significantly although CPR continues to be low. This indicates that when estimation of abortion prevalence is made, the factor of changed birth rate should be taken into cognisance.

In order to have a greater appreciation of abortion prevalence, abortions per 1000 births and abortions per 1000 women in age group 15-44 have been presented in Table 3. It may be observed that for India abortion rate stands at 452 abortions per 1000 live births in 1991. The state level analysis indicates that while Goa, followed by Kerala and Nagaland have the highest abortion rates, the state of Madhya Pradesh has the lowest abortion rate (372 abortions/1000 live births).

Trends In Reported MTP

Reviewing the official figures available for MTP, it is observed that the number of MTPs has increased from 0.278 million in 1976-77 to 0.632 million in 1991-92, an increase of about 8.49 per cent per annum. The number of approved centres for MTP also increased from 2149 in 1976-77 to 7121 in the corresponding period, showing an increase of about 15.42 per cent per annum (Table 4). Comparing the two trends it is evident that the performance of MTP has not kept pace with the expanding network of MTP centres, although the latter itself is inadequate to cater to the actual needs. This raises questions regarding both health policy planning and the health delivery system.

The trends in reported MTPs and approved institutions indicate that, by and large, their growth was corresponding with few exceptions in the seventies and mid-eighties. After the mid-eighties, the growth in MTP centres was higher than the growth in MTPs. In fact 1987-88, 1988-89 and 1990-91 show negative growth rates in MTPs, including even a decrease in absolute numbers, despite significant growth in approved institutions in the preceding years. The year 1991-92, however, marks a change. The growth in MTP has been to the extent of 8.8 per cent, although the growth in approved institutions in the preceding year was only 2.66 per cent. Even absolute numbers have increased by 51,000, vaulting the 0.6 million mark for the first time.

Table 3
Abortion Rates

S.No.	STATES/UTs	Abortions per 1000 Live Births	Abortions per 1000 Woman in 15-44 Age Group
1.	Andhra Pradesh	512	60.21
2.	Arunachal Pradesh	413	
3.	Assam	431	54.58
4.	Bihar	434	62.55
5.	Goa	590	
6.	Gujarat	485	58.01
7.	Haryana	403	63.34
8.	Himachal Pradesh	468	
9.	Karnataka	495	58.38
10.	Kerala	728	52.02
11.	Madhya Pradesh	372	63.99
12.	Maharashtra	508	60.77
13.	Manipur	663	
14.	Meghalaya	411	
15.	Mizoram	NA	
16.	Nagaland	720	
17.	Orissa	467	60.24
18.	Punjab	481	60.39
19.	Rajasthan	380	64.62
20.	Sikkim	592	
21.	Tamil Nadu	614	56.20
22.	Tripura	546	
23.	Uttar Pradesh	373	67.92
24.	West Bengal	493	60.23
25.	A&N Islands	666	
26.	Chandigarh	431	
27.	D&N Haveli	428	
28.	Daman & Diu	477	
29.	Delhi	539	
30.	Lakshadweep	491	
31.	Pondicherry	694	
	INDIA	452	

Equally significant is to note the average number of MTPs performed per institution. These had reached an average, of 120 over the early eighties, but plumetted to 85 by 1990-91. The average of 89 in 1991-92, shows a slight recovery of efficiency (Table 4).

Table 4
Performance of MTP

Year	No. of Approved Institutions	Increase in no. of Institution over previous Year (%)	No of MTPs Performed	Increase in No. of MTPs over previous Year (%)	Average No. of MTPs per Institution
1972-76	1877	-	381,111	-	-
1976-77	2149	-	2,78,870	-	130
1977-78	2746	27.8	2,47049	-11.4	90
1978-79	2765	0.7	317732	28.6	115
1979-80	2942	6.4	360838	13.6	123
1980-81	3294	12.0	3,88,405	7.6	118
1981-82	3908	18.6	4,33,527	11.6	111
1982-83	4170	6.7	5,16,142	19.1	124
1983-84	4553	9.2	5,47,323	6.0	120
1984-85	4921	8.1	5,77,931	5.6	117
1985-86	5528	12.3	5,83,704	1.0	106
1986-87	5820	5.3	5,88,406	0.8	101
1987-88	6126	5.3	5,84,870	-0.6	96
1988-89	6291	2.7	5,82,161	-0.5	93
1989-90	6681	6.19	5,96,357	2.4	89
1990-91	6859	2.66	5,81,215	-2.5	85
1991-92	7121	3.82	6,32,526	8.8	89

Source: Derived from *Family Welfare Year Books*, and Unpublished Data, Ministry of Health and Family Welfare.

It is evident that the approved MTP institutions have remained under-utilised for MTPs. The data indicates that at present, on an average, each institution performs an average of one MTP in 3 working days. This may be contrasted with earlier expert projections which had calculated an average

workload of 3-4 MTPs per trained physician, working part-time.[48] Thus, while on the one hand MTP performance shortfalls actual needs by a factor of ten; on the other hand, the work output of the trained physician is about a tenth of their optimum level of functioning in this sphere.

Regional Variations

The performance of MTP across the States reveals significant variations. The two top performers, (within the limited performance data turned in) are the states of Uttar Pradesh and Maharashtra. Cumulatively, Uttar Pradesh accounts for 18.4 per cent of the MTPs conducted so far and Maharashtra for 16.3 per cent. However, in the past several years Maharashtra has been accounting for about one fifth of the MTP cases in India.

Tamil Nadu cumulatively accounts for over 10 per cent. Other major contributors are - West Bengal (7 per cent) followed by Kerala (6.5 per cent); and, Delhi (5.3 per cent). Thus, 3 states - Uttar Pradesh, Maharashtra, Tamil Nadu together account for nearly 45 per cent of the officially reported MTPs in India, while having only a third share of the country's population.

When the share of States in MTP and total population is compared, it gives an interesting picture. For instance in 1991-92 Maharashtra with 9.4 per cent of population accounted for 20.07 per cent of MTPs; and Uttar Pradesh with 16.5 per cent of population accounted for 19.13 per cent of MTPs. West Bengal with 8.12 per cent of population accounted for 8.80 per cent MTPs in 1991-92 and 7.09 per cent cumulatively.

On the other end, Bihar with 10.30 per cent of population accounted for only 1.64 per cent of MTPs in 1991-92 and 2.09 cumulatively; Andhra Pradesh with 7.93 per cent population accounted for 1.70 per cent MTPs in 1991-92 and 2.69 per cent cumulatively. Thus, since 1991-92, when there is a slight pick up in overall MTP performance, the better performing states are generally doing better; but the backward states in cumulative performance are returning even lower proportionate shares. Moreover, this lag cannot be explained in cultural terms. Uttar Pradesh and Bihar have a similar ethos for instance, but very different MTP performance levels. At the same time Bihar is also reported to be a "good market" for private sales of MTP/MR equipment.

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[48] Family Planning Association of India (1973), *Medical and Social Aspects of Abortion*, p.48.

Inequity in Distribution of Approved MTP Centres

What is apparent from the comparison of population percentages, the share of MTP approved centres, and the share of MTP performance is that there are vast differentials between states that are not accounted for by the population's requirements. Nor do these differentials necessarily correlate with performance.

Maharashtra alone accounts for 22 per cent of the country's approved institutions for MTP. Maharashtra along with 4 other states and one UT - Gujarat, Kerala, Tamil Nadu, West Bengal and Delhi - account for 56 per cent of the approved institutions, but contain only a third of the country's population.

As Table 4 indicates in the State of Mizoram one approved institution is available for 4200 couples on an average. On the other end is Meghalaya, with an average of as many as 243,000 couples covered by one approved institution.

Table 5
State-wise Distribution of Population and MTP

Sl. N.	State/UT	Percentage Population (1991)	Percentage Cumulative MTP Since Inception to 1991-92	Percentage MTP 1991-92	Per centage MTP Centres 1991-92	Couples per MTP Centres (in '00) 1990
1.	Andhra Pradesh	7.93	2.69	1.70	5.20	308
2.	Arunachal Pradesh	0.10	0.11	0.15	0.15	114
3.	Assam	2.67	2.25	2.59	0.46	1091
4.	Bihar	10.30	2.09	1.64	1.62	1325
5.	Goa	0.14	0.26	0.25	0.73	36
6.	Gujarat	4.93	3.39	2.50	9.59	101
7.	Haryana	1.96	2.26	3.17	3.20	126
8.	Himachal Pradesh	0.62	0.98	1.04	2.19	54
9.	Jammu & Kashmir	NA	0.02	NA	NA	NA
10.	Karnataka	5.36	3.01	2.04	6.61	154
11.	Kerala	3.47	6.59	5.81	7.47	120
12.	Madhya Pradesh	7.89	4.59	4.89	4.01	388
13.	Maharashtra	9.41	16.37	20.07	22.72	80
14.	Manipur	0.22	0.41	0.66	0.51	64
15.	Meghalaya	0.21	-	-	0.01	2454
16.	Mizoram	0.08	0.00	0.10	0.28	42

Sl. N.	State/UT	Percentage Population (1991)	Percentage Cumulative MTP Since Inception to 1991-92	Percen-tage MTP 1991-92	Per cent-age MTP Centres 1991-92	Couples per MTP Centres (in '00) 1990
17.	Nagaland	0.14	0.11	0.08	0.18	100
18.	Orissa	3.78	3.72	3.41	2.37	305
19.	Punjab	2.42	3.42	2.44	3.47	119
20.	Rajasthan	5.25	3.12	4.23	4.44	193
21.	Sikkim	0.05	*	*	*	*
22.	Tamil Nadu	6.66	10.26	7.88	7.29	205
23.	Tripura	0.33	0.29	0.17	0.04	1272
24.	Uttar Pradesh	16.59	18.51	19.13	5.96	540
25.	West Bengal	8.12	7.09	8.80	6.35	230
26.	A & N Islands	0.05	0.00	0.05	0.01	452
27.	Chandigarh	0.08	0.45	0.29	0.03	607
28.	Dadra & Ngr.Haveli	0.02	0.01	0.01	0.01	226
29.	Daman & Diu	0.01	-	-	-	70
30.	Delhi	1.12	5.42	5.12	2.64	79
31.	Lakshadweep	0.01	0.00	0.00	0.03	38
32.	Pondicherry	0.10	0.31	0.34	0.10	194

* MTP Act not applicable.

The distribution of States where the share of population exceeds share of MTP and vice-versa is presented in Table 6.

Table 6
Classification of States on the Basis of Percentage Share of Population and Percentage Share of MTP

% Population Exceeds % MTP	% MTP Exceeds % Population
Andhra Pradesh, Assam, Bihar, Gujarat, Karnataka, Madhya Pradesh, Meghalaya, Nagaland, Orissa, Rajasthan, Tripura, Dadra & Nagar Haveli, Daman and Diu, Lakshadweep.	Arunachal Pradesh, Goa, Haryana, Himachal Pradesh, Jammu & Kashmir, Kerala Maharashtra, Manipur, Mizoram, Punjab, Tamil Nadu, Uttar Pradesh, West Bengal, A & N Islands, Chandigarh, Delhi, Pondicherry.

In a state level analysis of the major states Maharashtra appears to have the best availability of MTP services: one approved institution for 8000 couples. In contrast Bihar has the poorest network: one approved institution for 132,000 couples.

The highly skewed balance between states is further skewed within the state. Urban locations account for the majority of MTP institutions, despite three-quarters of the population being in rural areas. Government provision of MTP approved institutions in rural areas remains very limited to date - although efforts to ensure one trained physician and suction equipment in every PHC have been promoted since the early 80s. Of the over 20,000 PHCs in the country, all of which are eligible under the MTP Act to offer MTP facilities, only 1800 are reported to be actually providing MTP services in the 90s.

Even in Maharashtra, the windowcase state having a concentration of approved institutions, only 176 out of 1646 functioning PHCs in the State are recognised for extending MTP facilities. Further, despite the large number of recognised institutions in Maharashtra, with a 50 per cent increase accomplished since the mid-80s, performance levels remain unaffected, or even marginally lower. The city of Bombay, accounts for more than half of Maharashtra's MTP procedures. Within Bombay one single NGO contributed almost 45 per cent in 1992-93. By contrast, 8 women's hospitals across the state, between them accounted for less than 5000 MTPs or around 4 per cent. The average performance per institution in 1992-93 was 70 MTPs, lower than the national average.

In Uttar Pradesh where there is 75 per cent more population than Maharashtra, there are 70 per cent less approved institutions. However, the number of MTPs carried out in Uttar Pradesh are of a comparable level. In Uttar Pradesh the average number of MTP procedures performed per approved institution was nearly 225 in 1991-92 - considerably more than the national average. But it is still less than one MTP per working day, in a state likely to be having over a million abortions a year.

Variations by Provider

The average 0.6 million MTPs now reported in the country are the termination procedures carried out by qualified physicians in approved institutions duly reported after being undertaken. There are several reasons to believe that at least as many more procedures are being done by legally qualified physicians who fail to report on their work.

For one thing, default in reporting from institutions is considerable and consistent. The case of Maharashtra, one of the better administered states, illuminates this reality. Over the last four years as many as 20-30 per cent of the approved institutions defaulted totally in reporting.[49] Under reporting by reporting institutions is also not to be ruled out on several counts :

- the cumbersome nature of the reporting procedures requiring very detailed and time bound submission;
- the well known fact of private practice by physicians attached to public facilities; and
- the equally well known fact of private physicians' reluctance to divulge the true extent of their professional practice for fear of attracting higher tax liabilities.

A senior govt. health specialist in one of the larger states estimates the underreporting of legal abortions in that state by 100 per cent.[50]

The ICMR survey on illegal abortion has highlighted the trend of preference for qualified doctors and approved institutions. However, poor knowledge of available MTP facilities and poor accessibility, together with lack of courteous, compassionate interaction by public health staff and the MOs proclivity to do MTPs at their own private clinics are push factors away from the public health providers and facilities. The client's need for special attention and secrecy also provide pull factors for the private sector.

Accordingly, private practitioner doctors emerge as the preference of the second largest majority of the respondent sample, even when free services are available at the PHC. Public doctors acting in their private capacity and private sector doctors, including from different systems of medicine, service this need.[51]

This constitutes a mix of legal, safe, albeit unreported MTP and unsafe abortion; as, all physicians are not necessarily trained in MTP techniques or working out of places with the requisite facilities. Practitioners of the indigenous systems of medicine are at present not eligible to be trained for MTP.

For the two states for which the ICMR study was able to get specific information (Table 7) private doctors outstripped government providers in Rajasthan and recorded a good performance in Tamil Nadu, bearing out the general perception evident in many other studies that private sector doctors constitute a key provider resource.

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[49] State Reports (unpublished)
[50] Personal Communication
[51] ICMR (1989), *op cit.* pp.81-85.

Table 7
Providers of Abortion Services

			No. of abortions done	
			Rajasthan	Tamil Nadu
1.	*Private Doctor*			
	Allopathic	Male	217	10
		Female	172	160
	Ayurvedic/Homeopathic/	Male	70	62
	Unani etc.		**459**	**232**
2.	*Indigenous*			
	Dais	Trained	333	145
		Untrained	439	524
	Magician/Witch/Ojha:			
	Other indigenous			
	providers:		29	-
			801	**669**
3.	Chemist &		188	-
	Others		133	-
			321	
4.	*Govt. Doctor*			
	PHC Doctor	Male	217	-
		Female	97	-
	Other than PHC Doctor:		12	-
			326	-
5.	*Other Govt. Staff*			
	ANM		265	140
	LHV		17	-
			282	**140**

Source: ICMR (1989) *Illegal Abortion in Rural Areas, A Task Force Study*, New Delhi.

However, as seen from the above, the abortions done by indigenous providers were found to be even greater than those done by the Govt. doctors as well as the private doctors combined in Rajasthan, while it outstripped the available figures from private doctors only in Tamil Nadu.

In the ICMR study the dais trained and untrained emerge as the single largest category of providers, outstripping the combined government and private doctor output in Rajasthan; in Tamil Nadu their services cover manifold the numbers covered by private sector doctors.

Female, paramedics, that is, ANMs and LHVs, another unauthorised group, constitute another important category catering to significant proportions - roughly 13 per cent of the abortions performed.

Chemists and "others" also have a fairly significant role in Rajasthan; even witch doctors, ojhas and magicians are seen to be at work, while this is not the case in Tamil Nadu. Earlier studies[52] have similarly pointed to the majority of induced abortions being conducted by local dais and non-medical persons. Detailed case studies, undertaken in Orissa where the abortion rate was found to be phenomenally high amongst the ICMR surveyed states, document abortion practices that show "the crudest and most inhumane methods and materials (are) being used by the providers... their practices are highly unhygienic". But "the women needing abortion in underserved areas have no choice." Thus, while there may be differences in the degree and levels of illegal abortions by unauthorised providers, the phenomenon itself is widespread across the country.

It may be worthwhile to examine the characteristics of the providers of illegal abortion, particularly with respect to their education, experience and techniques. The study conducted by ICMR indicated that a large number of providers in the states of Rajasthan, Orissa and Tamil Nadu were illiterate. Interestingly, in Uttar Pradesh, a significant number (44.3%) of providers were literate diploma/degree holders (other than MBBS) and mainly males. As far as the experience is concerned, most of the providers were found having experiences of 5-10 years of conducting abortions. In general, among illiterate providers females predominate; among literate providers, the situation is the reverse.

Significant distributions of providers in the ICMR study pointed out that women seek other help because:

- There is no proper care at PHC/no medicines are given/no follow up care is given
- PHC does not maintain secrecy of the client
- PHC doctor charges too much money
- PHC is far off.

[52] Philips & Ghouse (1976) Chaturachinda et al (1981) etc.

Client Perception of MTP

A number of other studies underline similar issues: that women opt for non-approved centres/services for a variety of reasons, ranging from apathy of the doctors to poor quality of services. A study by Roy et al, which analysed the cases which dropped out from hospitals after a few visits, indicated that the doctors insisted on sterilization alongwith abortions: procedural delays often brought women into advanced stages of pregnancy. A significant number of these women took recourse to private services. The ICMR rural study also found a low level of awareness of the MTP legislation and services. However, a more recent study done in UP shows that awareness of legal facilities is fairly high, but not necessarily correlated with utilisation.[53]

The ICMR study has revealed interesting features as to why a large number of women do not seek abortion under the MTP framework. It has been observed that a variety of factors are responsible. The majority of respondents (42.5 per cent) in the total 5 state sample disclosed that this was mainly because of the "satisfaction" one gets from the services offered by the private providers. This was followed by the second large majority of respondents (27.6 per cent) who for the "secrecy" reason had shown preference for the provider other than the PHC doctor. The third largest majority (19.9 per cent) revealed that because of the "dissatisfaction" about the services provided by the PHC doctors the other providers were preferred. This reason could be seen together with the first one as these refer to the same dimension of services. Interestingly, some of the personal reasons, like "own willingness", "pregnancy due to illicit sexual relations" and "kind services" etc., converging into the "others" category, were also offered by a sizable proportion of respondents (15.8 per cent).

In all the other states, except Orissa, the "satisfaction" from the services provided by the private doctor/provider emerged as the main reason for preference for the private providers in the majority of the respondents. In Orissa also, this reason was expressed for such preference but the other one was "dissatisfaction" from the services provided by the PHC doctor.

These two reasons, if merged together, represent a very large majority of respondents in the combined sample of all the 5 states as well as in the individual state sample. If so done, the "secrecy" then would appear as the next important reason in Uttar Pradesh, Rajasthan and Haryana. While in Orissa

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[53] Vimarsh (1991) "KAP of Health Functionaries and ISM Practitioners in the context of Delivery of MTP services", New Delhi, (Mimeo).

and Tamil Nadu, the next reason would be easy ''accessibility'' and ''personal reasons'' (like own willingness, pregnancy due to illicit sexual relations and kind service etc.) respectively.

Thus, it is clear that most of the respondents in the combined sample and individual state samples indicated that the women preferred private doctor/provider for undergoing abortions even when free MTP services were available from the PHC because of the main reasons, like ''service satisfaction'', ''secrecy'', personal reasons put under the ''others'' category and easy ''accessibility'' to private providers.

Demand For Abortion

Characteristics of Women Seeking Abortion/MTP: Overall Findings from Studies

A large number of studies have explored the background characteristics, knowledge and attitudes of women seeking abortion/MTP services. Most of these studies have been hospital based and thus have an urban bias; but they include a large rural community survey.

An uniform insight on the characteristic profile of women seeking abortion in India is that an overwhelming majority are adult, married women with children, who are either wanting no more or desiring to space the next pregnancy better. Most studies also find other socio-economic and religious factors to reflect the general composition of the population, suggesting abortion to be an universal need cutting across communities, classes and even religious cultural backgrounds. A few studies however document Muslim opposition or lower rates of acceptance. While variation exists in the percentage of the unmarried or otherwise single women identified as seeking MTP services, the share of this group is acknowledged to be limited in all assessments. It is, however, noted that they constitute a significant, vulnerable high risk group prone to postpone the issue and therefore a substantial share of the second trimester terminations. The majority of the women seek termination within the first trimester. But, second trimester abortions are rising, as also the numbers of the young, unmarried; however, both still constitute a small percentage of the total. A mixed trend is noted with regard to education. Several studies note more utilisation by the educationally better off; while, others find the proportion of illiterates matches the composition of educational indicators.

ICMR Findings

An exhaustive literature review done by ICMR in 1989 indicates that the majority of women in India seeking pregnancy termination to be in their twenties[54]. The majority were married[55] multiparous, with at least 3 children or more;[56] The majority of those seeking abortion were from poor income groups[57] and comprised of a high percentage of illiterates and of Hindus. However, neither the socio-economic characteristics nor religion provided any specific indicators other than the fact that they reflected the general population. Sarkar (1977) however found opposition to abortion mostly among Muslims and least amongst Hindus. Variation exists in the percentage of the unmarried seeking pregnancy termination in these studies.

ICMR's own two major studies on abortions generally bear out the literature review. One multicentric study noted the majority (90 per cent) to be married; with one or more children, not wanting any more; nearly 85 per cent with a per capita income below Rs. 150 a month; and, over 80 per cent in the age group 20-35. However, this study carried out in major teaching hospitals in urban areas, found the majority of women seeking pregnancy termination to be from educationally better segments of the population - more than half the women and over two thirds of their husbands were having precollege or college education. Unmarried women (5.4%) teenagers (5.2%) and nullipara (7.6%) formed a small but high risk group[58]. They reported, more often, in the second trimester.

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54 Philips & Ghouse (1976) Rajasekaran & Vijaya (1973) Bhatt & Soni (1973) Kanitkar & Rao (1974) Mukhopadhyay & Das (1975) Jain & Devi (1976) Alwani et al (1976) Bose & Sethna (1980) Gupta (1976) Yadhava et al (1979) Krishnamurthy and Manu (1979) Soni et ai. (1976) Bhatia (1973) Narkavonniakit (1979) Flaviar and Chen (1980) Chaturachinda et al (1981) Vekemans and Dohmen (1982) Kelting and Schnabel (1980) Narkavonniakit and Benneth (1981) Goraya et al (1977)

55 Rajasekaran and Vijaya (1973), Bhatt and Soni (1973), Kanitkar and Rao (1974), Jalnawala (1975), Mukhopadhyay and Das (1975), Khandwala and Pai (1975), Jain and Devi (1976), Alwani et al. (1976), Panday (1979), Upadhyay (1979), Yadava et al. (1979), Krishnamurthy and Manu (1979), Thakore et al. (1974), Chaturachinda et al. (1981), Bhatia (1973), Goraya et al. (1977).

56 Mukhopadhyay and Das (1975), Jain and Devi (1976), Alwani et al. (1976), Kanbargi and Kanbargi (1977), Panday et al. (1979), Upadhyay (1979), Gupta (1976), Kanbargi and Kanbargi (1977), Panday et al. (1979), Soni et al. (1976), Goraya et al (1977), Thakore et al (1974), Narkavonniakit (1979), Chatur Achinda et al. (1981), Schnabel (1980), Bose and Sethna (1980), Philips and Ghouse (1976), Kanitckar and Rao (1974), Khandwala and Pai (1975), and Rajasekaran and Vijaya (1973).

57 Kanitkar and Rao (1974) Mukhopadhyay and Das (1975) Khandwala and Pai (1975) Upadhyay (1979) Gupta (1976) Krishnamurthy and Manu (1979) Soni et al (1976) Tietze (1983) and ICMR (1981)

58 ICMR (1981) *Collaborative Study on Short Term Sequelae of Induced Abortion*, pp.4-8.

The other study, in rural areas, found the age pattern to be similar : 20-35, years but again reinforced the view of the majority (above 60 per cent adopters) being illiterate. The majority to be from the segments earning less than Rs. 150 a month (except for seekers of legal abortion in Rajasthan and Haryana, who numbered 50 per cent and 42 per cent respectively). Marital status had a more mixed picture in this study. The majority in Uttar Pradesh and Rajasthan were married, but categorised in a confusing nonspecific manner in Orissa and Tamil Nadu; the unmarried category remained small in Orissa and was not filled at all in Tamil Nadu. The majority were housewives and Hindus. The majority of upper caste Hindu women were found to have availed of legal abortion, while the greater percentage of Hindu SC/ST and other religions resorted to illegal abortion. With the exception of one state - Uttar Pradesh a higher percentage of illiterate women were found to be seeking illegal abortion, perhaps because of a lack of appropriate knowledge about the available facilities. Income above Rs. 150 per month also created a positive variable for legal abortion.[59]

Recent Studies

A more recent analysis of data from public hospitals in three urban centres[60] have also found the majority of women being young (mean age 28 years), married (90 per cent), multiparous (in general 2 or more living children and at least one living son); and relatively better educated than their counterparts among the general population. The study identified 34 unmarried MTP acceptors out of the 1220 studied - less than 3 per cent. Of these, however, half were below 18; two-thirds belonged to a high caste and an equal proportion had some schooling; half belonged to families with income below Rs. 1000 per month and the other half to middle class families.

Gestation

The earlier studies on septic and illegal abortions highlight the majority of abortions to be within the first trimester and a small number in the second trimester[61].

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[59] ICMR (1989) *op cit*, pp.134-139.

[60] Khan, M.E. et al. "Abortion Acceptors In India, observations from a Prospective Study" (Mimeographed).

[61] Philips & Ghouse (1976), Bhatt & Soni: (1973) Kanitckar and Rao (1974), Jalnawala (1975), Jain and Devi (1976), Panday (1979), Upadhyay (1979), Bose and Sethna (1980), Gupta (1976), Rao and Panse (1975), Yadava (1977), Krishnamurthy and Manu (1979), Goraya et al. (1977), Thakore et al. (1974), Bhatia (1973), Chaturachinda et al. (1981), Soni et al. (1971), and ICMR (1981).

Nevertheless, India is considered to have one of the highest proportions of second trimester abortions in the world.[62] The ICMR Task Force Study found second trimester abortions to be more than 11 per cent of the cases in Rajasthan and Uttar Pradesh, and as much as 60 per cent in Orissa and 35 per cent in Tamil Nadu. Further, the study noted as much as 11% of these abortions to be in the third trimester[63]

A study by Kanbargi (1975) indicated that the incidence of second and third trimester abortions were more frequent among unmarried women, younger married women, and women in the age group of 40+. It was also found that the incidence of second and third trimester abortions were more in Muslim women as compared to Hindu and Christian women. An association of second and third trimester abortions with low literacy and low income was also observed.[64]

Reasons for Abortion

There are studies which indicate that reasons for abortion outside the framework of MTP are multifarious. They vary from financial constraints to unmarried status etc. Jalnawala, (1975) attributed 17.9 per cent abortion cases to environmental reasons. Mukhopadhyay and Das (1975) found that multiparity with socio-economic status was the predominant cause of illegal abortion.

Several studies attribute a higher percentage of abortions to contraceptive failure - Jalnawala (1975) - 56 per cent; Khandwala and Pai (1975) - 64.6 per cent; Rao and Panse (1975) - 57 per cent; Thakur et al (1974) - 75 per cent.

A study by Khan et al (1990) observed that 67 per cent of the MTP acceptors had achieved their desired family size. About 27 per cent felt that their last child was too young and 16 per cent of the acceptors wanted to delay the birth of the next child. This study also noted that in the case of 56.4 per cent of those who were using contraceptives, pregnancy was caused because of irregular use, and in 43.6 per cent cases, the method itself failed.

The ICMR study (1989) indicates that a majority of women opt for abortion because of "already many children". This prime reason is followed

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[62] Tietze, C. *op cit.*, p.65.

[63] ICMR, (1989) *op cit*, p.115.

[64] Kanbargi, Ramesh (1975) "Induced Abortions in Bangalore City" 1972-74" (Mimeo)

by poverty/poor economic conditions in Uttar Pradesh; spacing/"last child very young" in Rajasthan and social taboo for unmarried girls etc. in Orissa and Tamil Nadu. While contraceptive failure is one of the major reasons given by MTP seekers for undergoing MTP in approved institutions, the attitude of health functionaries is found to be often ambivalent on this score. A large study in Uttar Pradesh[65] indicated that medical officers generally advise women to go for MTP in such cases. However, in the case of Health Supervisors, while the majority of male supervisors advised women for MTP, the female supervisors advised the women to continue with the pregnancy as MTP is not good for health. Interestingly, the majority of multi-purpose workers also do not favour MTP in case of contraceptive failure.

Findings from MTP Data

MTP data collated at the Centre from state reports relates to only 4 elements of the characteristics of women seeking pregnancy termination:

(i) Age of the woman; (ii) duration of the pregnancy; (iii) reasons for seeking abortion; and (iv) contraceptive acceptance. Data trends over the past five years are analysed in the following paragraphs.

Age

Age composition of MTP cases for the 5 years period 1986-91 is presented in Table-8. It is seen that more than 80 per cent of the MTP seekers belong to the age group 20-34 years. This is in line with earlier findings. The percentage of teenage girls seeking a termination is between 6-9 per cent; at the other end of the spectrum, older women comprise around 10-11 per cent. However, a substantial segment - 15 per cent in 1990-91 but as much as 29 per cent in 1986-87 - with age data not available could point to a higher teenage MTP incidence than is being actually recorded.

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[65] Vimarsh, *op. cit.*

Table 8
Distribution of MTP Cases by Age

Age	1990-91	1989-90	1988-89	1987-88	1986-87
Less than 15					
No.	1991	2599	1726	614	921
%	0.5	0.4	0.3	0.1	0.2
15-19					
No.	32066	41846	36158	24091	26025
%	6.6	8.4	7.1	5.7	6.4
20-24					
No.	128611	131540	142217	117247	112522
%	26.3	26.4	27.9	27.5	27.7
25-29					
No.	168782	167718	165788	147412	136511
%	34.5	33.7	32.5	34.6	33.6
30-34					
No.	104861	102747	106213	88829	85232
%	21.5	20.6	20.8	20.8	21.0
35-39					
No.	41998	43974	46558	38586	36942
%	8.6	8.8	9.1	9.0	9.1
40-44					
No.	7220	7349	9463	8384	7171
%	1.5	1.5	1.9	2.0	1.8
45 Above					
No.	3087	628	2024	1125	1009
%	0.6	0.1	0.4	0.3	0.2
Not Avail					
No.	89815	95259	51040	138615	165913
%	15.5	16.0	9.1	24.5	29.0
Total	**578431**	**593660**	**561187**	**564903**	**572306**

Source: Derived from Dept. of Family Welfare, Ministry of Health & Family Welfare, *Yearbooks* & Unpublished Data.

It is further evident from Table 8 that the share of MTP cases in the age group of less than 15 years increased between 1986-87 and 1990-91. Both the actual figures and the increase are marginal. But, the fact that the increase has taken place merits attention. In fact the share of the 15-19 age group too increased during 1987-1988 and 1989-90.

Gestation Period

An analysis of data of MTP seekers by duration of pregnancy indicate that around four-fifths of terminations clearly take place in the first trimester. In fact, this proportion increased between 1986-87 and 1988-89. However, the subsequent period has shown a significant decline in first trimester cases. The percentage share was as low as 74.92 in 1990-91. This point merits special attention because dangers of termination increase substantially with each week of gestation regardless of medical care. Second trimester is manifold more dangerous than early first trimester.

The increasing trend of second trimester abortions over the last five years, as also the sharp reversal of the earlier decrease of the percentage of "not available" cases (now nearly 10 per cent in 1990-91) is a cause for great concern. The increase in second trimester terminations could also have a link with foetal sex-determination tests, which are dealt with in a separate section later.

Table 9
Distribution of MTP Cases by Duration of Pregnancy

	1990-91	1989-90	1988-89	1987-88	1986-87
Upto 12 weeks					
No.	433396	452461	461825	444502	420279
%	74.92	76.21	82.29	78.43	73.43
12 to 20 weeks					
No.	452461	95715	81701	84017	70900
%	15.69	16.12	14.55	14.87	12.38
Not available					
No.	54253	45484	17661	36384	81127
%	9.37	7.66	3.14	6.44	14.17
Total	**578431**	**593660**	**561187**	**564903**	**572306**

Source: Department of Family Welfare, Ministry of Health and Family Welfare, *Year Books* & Unpublished Data.

Reasons for Abortions

The MTP Act 1972 postulates certain conditions under which a woman can get her pregnancy terminated in an approved institution. Therefore, it is not very

surprising that women who seek services at these centres indicate one of the prescribed reasons for getting a pregnancy terminated. However, the profile is not different from what the various studies discussed earlier have highlighted. The country picture is presented in Table 10 in this regard.

It may be observed from the above that the largest category - above two-fifth of the women take recourse to MTP because of contraceptive failure. This is a significant aspect as it indicates:

- Use of ineffective contraceptives, and/or of less effective methods / methods not in the woman's own control (e.g. condom);
- Lack of knowledge about the proper/sustained use of contraceptives; and
- Contraceptive method failure per se.

Table 10
Percentage MTPs By Reasons

	1990-91	1989-90	1988-89	1987-88	1986-87
Danger to Life	11.1	23.8	11.4	11.5	9.5
Gross Injury for Physical Health	17.5	17.8	17.1	17.5	18.5
Gross Injury for Mental Health	13.7	10.8	13.3	12.2	12.8
Rape	0.7	0.8	0.8	0.9	1.2
Substantial Risk	7.4	7.4	8.4	9.6	9.2
Contraceptive Failure	42.2	30.8	39.1	35.6	39.5
Environmental Reasons	7.4	7.9	10.1	12.7	9.3
Not Available	26.5	18.7	21.7	25.8	30.0

Source: Department of Family Welfare, Ministry of Health and Family Welfare, *Year Books* & Unpublished Data. (Catergery of Not Available is excluded).

Over a quarter of the women indicate severe health problems, including Threats to life - a pointer towards Debilitation of women by repeated pregnancies and the exhausted condition of their bodies from bearing of multiple role burdens. Around 13 per cent are categorical about injury to mental health - clearly indicating the trauma imposed by repetitive, unwanted pregnancies. Thus, nearly 40 per cent are physically or mentally traumatised by

unwanted pregnancies. But even within the teenage/nulliparous category of women it is reported by doctors at MTP centres that there is a considerable percentage of newly married couples who do not use contraceptives and end up opting for MTP.

These aspects point to continuing problems with the contraceptive information and delivery services in India. However, it is necessary to also note recent presentations at international meetings which highlight that with even 95 per cent effective usage of contraception - families seeking to adopt the two child norm, 7 out of 10 women will seek at least one abortion in a lifetime.

MTP and Contraception

Contraceptive failure is one of the important reasons given by MTP seekers for under-going MTP in approved centres. At the same time, the profile of the MTP seeker shows her to be mostly multiparous, either not wanting anymore children or wanting to space out the pregnancies. However, the share of those accepting an effective contraceptive method - terminal or IUD - is less than half. The proportion not accepting contraceptive cover has increased from 51.8 per cent in 1986-87 to 54.2 per cent in 1990-91. Since 1988-89 there is a definite slide in the percentage of women taking concurrent sterilisation or IUD. While studies do not show any significant increase in risk, a worldwide shift is taking place. This will require renewed emphasis on post-abortion contraception but through counselling and care that is genuinely caring and non-coercive.

Table 11
Medical Termination of Pregnancy Cases with Sterilisation and IUD. 1986-87 to 1990-91

(In Per cent)

Years	With Sterilisation	With IUD	Without Sterilisation/ IUD
1990-91	28.5	17.3	54.2
1989-90	28.6	15.7	55.8
1988-89	29.6	20.9	49.5
1987-88	29.2	18.8	52.0
1986-87	29.6	18.6	51.8

Source : Department of Family Welfare, Ministry of Health and Family Welfare, *Year Books* and Unpublished Data.

There are substantial state level variations. While 87 per cent of MTP seekers in Tamil Nadu opted for sterilisation in 1990-91, only 8.1 per cent did so in Assam. Similarly, in the case of IUD, Chandigarh had half the MTP seekers and Delhi, Goa and Punjab had more than one third of MTP seekers accepting an IUD alongside the MTP, while Assam had only 4 per cent and Tamil Nadu a little over 7 per cent. Analysis of the cases without sterilisation/ IUD shows the highest percentage of these cases lie in Assam, followed by Uttar Pradesh and Maharashtra.

Mortality and Morbidity

Termination of pregnancy is an important maternal health issue, given both the scale of numbers of women in need, and the dire consequences of mishandling.

Abortion Deaths

According to one official estimate, death rate for legally induced abortion is 1.4 per 100,000 procedures as against 60-100 per 100,000 conducted by untrained persons.[66] Recent official statistics on deaths due to MTP indicate a negligible figure. Data for 1992-93 indicates no death at all. Given the need for considerable improvements in MTP services and monitoring, this could well indicate the need for more rigorous monitoring. However, within the MTP framework, there has been a steady decline in reported deaths since the eighties level (barring 1987-88, when an exceptionally high number of MTP deaths were reported). Over the nineties, the deaths reported have been primarily in one Union Territory - Chandigarh; the states of Maharashtra, Tamil Nadu and Andhra Pradesh have also experienced mortality.

Table 12
Percentage MTP With Sterilization and IUD 1990-91

Sl.	States/UT	With Sterilisation	With IUD	Without Sterilisation / IUD
1.	Andhra Pradesh	35.6	13.4	51.1
2.	Arunachal Pradesh	15.8	36.7	47.6
3.	Assam	8.1	4.2	87.7

66 MOHFW, Communication to States (Unpublished)

Sl.	States/UT	With Sterilisation	With IUD	Without Sterilisation / IUD
4.	Bihar	37.3	20.7	42.1
5.	Goa	31.3	38.5	30.2
6.	Gujarat	37.6	29.9	32.6
7.	Haryana	30.3	20.0	49.7
8.	Himachal Pradesh	39.5	22.4	38.0
9.	Jammu & Kashmir	NA	NA	NA
10.	Karnataka	17.4	20.1	62.5
11.	Kerala	14.8	17.3	67.8
12.	Madhya Pradesh	14.6	14.7	70.8
13.	Maharashtra	13.2	15.2	71.7
14.	Manipur	14.4	9.7	75.9
15.	Meghalaya	NA	NA	NA
16.	Mizoram	35.8	10.6	53.6
17.	Nagaland	NA	NA	NA
18.	Orissa	24.0	21.3	54.7
19.	Punjab	30.2	37.2	32.7
20.	Rajasthan	26.6	19.4	54.0
21.	Sikkim	NA	NA	NA
22.	Tamil Nadu	87.1	7.3	5.7
23.	Tripura	NA	NA	NA
24.	Uttar Pradesh	17.6	10.4	72.0
25.	West Bengal	41.0	22.7	36.3
26.	A&N Islands	69.7	23.2	7.0
27.	Chandigarh	43.1	50.1	6.9
28.	Dadra & Nagar Haveli	NA	NA	NA
29.	Daman & Diu	30.4	8.7	60.9
30.	Delhi	29.6	38.8	31.6
31.	Lakshdweep	NA	NA	NA
32.	Pondicherry	43.0	19.3	37.7
	India	**28.5**	**17.3**	**54.2**

Source : Ministry of Health and Family Welfare, Unpublished Data

Table 13
No. of Deaths recorded in MTP Programme - Yearwise

80-81	81-82	82-83	83-84	84-85	85-86	86-87	87-88	88-89	89-90	90-91	91-92	92-93
25	27	24	24	14	16	4	52	13	NA	9	7	NIL

Source: Ministry of Health and Family Welfare, *Year Books* & Unpublished Data.

Other sources indicate a considerable number of deaths due to abortions. Given the poor registration of vital statistics maternal mortality figures in India are known to be grossly underestimated. Still, in 1990, causes relating to childbirth and pregnancy were reported to take a toll of nearly 13 per cent of women dying in the prime of their lives (aged 15-44) in the rural areas.[67] A cause for grave concern is that the share of abortion in maternal death causes which was showing a decreasing trend after the mid-eighties, has more than doubled in the last few years. Having reduced to 5 per cent in 1988, deaths due to abortion have reverted once again in the nineties to levels prevailing in the late seventies. (Table 14). It is evident from the earlier analysis that the number of abortions has increased significantly and at the same time growth in MTP has been quite slow, indicating that deaths due to abortions outside the MTP framework have increased. This point needs detailed probing.

Table 14
Percentage of Abortion Deaths to Maternal Deaths
All India (Rural)

CAUSE / YEAR	YEAR 78	79	80	81	82	83	84	85	86	87	88	89	90
ABORTION	11.0	11.7	12.5	13.7	10.1	10.7	10.8	11.5	8.0	7.6	5.0	10.9	11.8

Sources: Model Registrar Scheme, *Survey of Causes of Death (Rural) 1984-1986* - A Report, Series 3 No. 17-19; Statement No. XIX, Registrar. Gen. Of India, New Delhi.

Govt. of India *Survey of Causes Of Death (Rural), Annual Report, 1990,* Office of The Registrar. Gen. of India, New Delhi.

[67] Govt. of India (1990) *Survey of Causes of Death, Rural. Annual Report, 1990,* Office of the Registrar General, New Delhi.

One tabulation of a large number of studies on unsafe abortion over the sixties to the eighties[68] shows abortion related deaths as a percentage of all maternal deaths in a range of 2.5 to 34 per cent; two separate studies from a large number of teaching hospitals across the country attribute it to be around 15 per cent. Given the maternal death estimates of around 400-500 per 100,000 live births, abortion related deaths in India at present can be conservatively estimated at 15 per cent - which is at least 15,000 - 20,000 a year. Practically all are preventable.

Late Abortions

Induced abortion at any period of gestation exposes a woman to some risk, which varies enormously depending upon the circumstances of the woman and the conditions under which the abortion is performed. Serious immediate complications are generally rare with abortions performed in medical settings.[69] However, data from all over the world indicate that second trimester abortion is more hazardous than first trimester. The stage of pregnancy at which an abortion is performed affects the risk of mortality and complications; regardless of the legal status and medical care, the risk of mortality rises with increasing gestation.[70]

India has one of the highest proportions of second trimester abortions amongst countries without legal restrictions,[71] as also considerably higher maternal and morbidity rates than noted in developed countries. An ICMR multicentric study shows second trimester mortality rates in India to be twelve times those of first trimester, even in teaching hospitals with all expertise and facilities available. Second trimester MTP mortality rates (321.9 per 100,000) were higher than maternal mortality in urban areas.[72]

The rural study by ICMR notes extensive use of private sector clinics/ hospitals, belonging to both allopathic and (to a lesser extent) indigenous system doctors in the case of second trimester abortion; also the use of the clients' own homes with trained/untrained dais performing the procedure, or chemists providing oral medicines.[73] This points to the need for better education and awareness of women, based on an understanding of underlying causes of the

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[68] WHO (1990) *Abortion: A Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion*,

[69] Tietze, C. *op cit*,

[70] Henshaw, Stanley K, *op cit*,

[71] *Ibid.*

[72] ICMR (1981) *Collaborative Study on Short Term Sequelae of Induced Abortion*, New Delhi.

[73] ICMR (1989) *op cit.*

delay in seeking relief, in order to significantly reduce the proportion of second trimester abortions.

The ICMR study also noted substantial differentials of mortality rates between different procedures of MTP. Mortality in all the methods specifically used for second trimester MTP is substantially higher than in those that generally serve for first trimester. There is also a six fold difference between mortality resulting from D&C or surgical curettage (the method still predominantly used in India) and suction curettage or vacuum aspiration promoted by GOI since 1980. Mortality by the vacuum aspiration method was noted to be 16/100,000 procedures as against 97/100,000 by D & C, Other methods ranged between rates of 189-502/100,000. The death to case rate in this study was 68/100,000. [74]

The overall incidence of complications - both immediate and delayed - of MTP was found to be low. Haemorrhage and cervical or uterine injury were the common immediate complications. Other major complications occurred in 2.1/1000 cases and minor complications were noted in 31.3/1000. Infections, such as pelvic infection, urinary infection and wound infection were the most important delayed complications, but these were rarely life threatening. Incomplete abortion due to incomplete emptying of the uterus was noted in 14/1000 and continuation of pregnancy due to ineffective attempts at MTP in 4/1000[75]. The complication rates noted in this study have been considered representative of morbidity and mortality in teaching hospitals. Information on other lower level medical institutions is too scattered and sparse, but will obviously be manifold. Guidelines for reduction in morbidity associated with MTP were devised following this study, but these would apply where legal MTP takes place.

With the increased number of abortions and the stagnation in the number of MTPs, the dangers of complications, major and minor, which can be very often unattended by proper health care - have accelerated. For instance, illegal providers of abortion in 2 of the 5 states studied by ICMR, took no remedial measures for heavy and prolonged bleeding following abortion in 92 per cent of the cases in Rajasthan and 40 per cent of the cases in Uttar Pradesh. In the latter, even pain in abdomen was ignored by 40 per cent of the cases. Certain other complications not specified were also ignored. Most simple complications were however treated by the providers by using preparations of different systems of medicine. Major complications were, however, referred to other providers whom they considered competent. Referrals to government hospitals were limited by comparison and therefore morbidity trends as noted by

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74 ICMR (1981) *op cit.*

75 *Ibid*

hospital-based studies are inadequately captured. Infertility and chronic ill health that can arise from unsafe abortions have serious public health implications besides their impact on individual suffering.[76]

Sex Selection and Abortion

The widespread use of sex determination technologies, now assuming the proportions of an epidemic in northern India in particular, is a matter of grave concern. It also poses some very ticklish issues to society in general and women in particular. The wholly legitimate anguish at regressive cultural and social mores that the use of these technologies brings to the fore is confronted by the desperate need of women whose prevailing circumstances make these technologies appear as a benign personal boon to them and their families.

Sex determination tests, as the by-product of genetic abnormalities diagnostic techniques, started in India in the mid seventies.[77] A brief report by this author drawing attention to the misuse of the genetic testing facility at the All India Medical Institute of Sciences (AIIMS) frontpaged by The Statesman, a leading national newspaper, led to a banning of these tests at AIIMS; and, subsequently, in other government hospitals in 1978. Between 1977-85 three circulars to Govt. Deptts.. at the Centre and the states made the use of prenatal sex determination for the purpose of abortion a penal offence.[78]

But by 1979 aminocentisis for sex determination had become widely available in private clinics. By the 1980s the facilities for sex determination tests had begun to be widely advertised. One report claims that in 1986-87 an estimated 30,00-50,000 female foetuses were aborted.[79] Another study shows that landless laborers and marginal farmers are willing to take loans at 25 per cent compound interest to avail of these tests.[80]

Since the late eighties sex determination facilities have multiplied extensively across the country. These have spread not only across the northern states well known for their poorer developmental indices on the status of women, but also to the western states (Gujarat and Maharashtra); the eastern region (West Bengal and Orissa), as also, the more progressive southern region (Andhra Pradesh, Karnataka and Tamil Nadu) and even the cosmopolitan state of Goa.[81]

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[76] ICMR, 1989, *op cit*, pp.110-113.
[77] Menon, Nivedita, (1993) "Abortion and the Law: Questions For Feminism", *CJWL/IRFD*, p.108.
[78] VHAI "Aminocentisis", (Memeo).
[79] *Ibid*
[80] Menon, Nivedita, *op cit*.
[81] VHAI, *op cit*.

Furthermore, a variety of technologies are in use - aminocentisis, chorion villi biopsy, foetal cell testing from maternal blood and ultra sonography. The latter is now the most routinely used technology.

The services are being blatantly advertised - including through large hoardings in cities and highways, media and mail letters. Training programmes for doctors are also advertised highlighting the lucrative nature of the work. Sex determination tests are being done not only in urban areas, but also in remote rural regions, which otherwise lack even basic facilities such as potable water. Ice packed samples are known to be transported long distances, including across state borders. Beyond sex determination tests, technologies for sex preselection are also being developed and popularised.[82]

In the wake of efforts by several women's groups, Maharashtra, in 1988, enacted legislation to regulate prenatal diagnostic tests. Goa and Gujarat have introduced similar legislation. Most importantly, Central legislation which will be applicable to the entire country, excluding Jammu and Kashmir, was introduced in Parliament in 1991. It is expected to be enacted this winter session.

The Government claims that it is bringing forward comprehensive legislation: this will regulate the prenatal diagnostic testing facilities and personnel and ban their use for purposes other than the detection of abnormalities as specified in the Act[83] or specified by the Central Supervisory Board to be created under the Act. However, ironically, the proposed legislation is very much on the pattern of the MTP Act which we have already observed to have been quite weak in implementation. Further-more, the experience of Maharashtra with 5 years of implementation of a similar legislation highlights inadequacies. While open mushrooming of clinics has halted - only 29 genetic testing clinics are registered under the Act - there is little evidence to believe that the sex determination testing has not simply gone underground. A number of medical doctors in Bombay pointed out that the tests have simply become more expensive and perhaps more unsafe for the woman, but certainly not been eliminated.[84]

Women's groups such as the Forum against Sex Determination and Sex Selection (FASDS) are unhappy that the ordinary citizen cannot take challenges to the court, but must approach the state appointed monitoring bodies with their complaints. The monitoring bodies can refuse to make records or

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82 *Ibid.*

83 Lok Sabha unstarred Question No.2662, August 12, 1991, cited in VHAI, *op cit.*

84 Personal Discussions

information available to complainants "in the public interest". The state, in turn, can overrule the monitoring body's decision to cancel or suspend a laboratory/clinic's license and/or further exempt a clinic laboratory from the provisions of the Act. These groups have not received any information following their enquiries on action so far.[85] FASDS and other NGOs are therefore pressing for appropriate changes in the clauses of the proposed Central bill to strengthen legislation towards greater public accountability. Even so, questions will remain as to how workable the legislative solution will be in the present Indian situation.

A section of feminist activists are also pointing out the limitations of the law as an agent of transformation and questioning more power being vested in state enforcement machinery to intrude into women's private lives.[86] It is pointed out that the debate in India over the selective abortion of female foetuses after sex determination tests has given rise to "very serious political contradictions" and "a profound philosophical incoherence within the feminist position".[87]

The woman's inalienable right of control of her body - "bodily integrity" - as also, consideration for her greater assumption of the social responsibilities of childrearing clash headlong with the demand for state curbs to legally prevent a woman from having the information she may wish to seek to make a specific choice that will fundamentally affect her being and lifestyle. Entire areas of science and knowledge are also seen to be handed over to bureaucratic control through the enactment of legal measures.[88]

The counterposing of the rights of future women to be born against the rights of present women to have control over their bodies and lives is one acute dilemma. The hazards of agitating against female foeticide which could - and is - stirring dormant profile forces in the country is another. It could begin to jeopardise the woman's right to abortion per se.

Women's groups are sensitive to this issue and have retracted on steps that could have been misconstrued, as for instance their earlier calls for revision of the MTP Act/Rules to incorporate constraints on MTP after sex determination. However, despite a clearcut separation of the two issues at this stage, problems of overlap still arise. The women's movement will have to develop appropriate strategies and educational campaigns that go beyond the rhetoric of foeticide and murder to eliminate the conflicts.

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[85] *Ibid*

[86] Menon, Nivedita, *op cit*; Agnes, Flavia, (1993) "A Critical Review".

[87] Menon Nivedita *op cit*.

[88] *Ibid*.

The social and ethical dimensions apart, there are critical negative health implications of sex determination tests that have been inadequately emphasised so far. Most sex determination tests are being conducted between 14-18 weeks, as genetic defects and sex can be diagnosed with relative certainty only about the 14th week. By the time the results are available and women take a decision to act, the temination is often beyond 20 weeks and illegal. But as earlier noted all second trimester abortions are highly hazardous to the women undergoing them. A vigorous educational campaign for the women, their families and the medical profession is obviously one requirement that has not been taken up seriously so far.

Recent census results highlight an aggravation of the declining female sex ratio. There is considerable speculation about the role of sex determination testing in the deepening imbalance. There can be no two opinions that negative social attitudes to women underpin this gross demographic distortion. However, it is important to put into perspective that this imbalance arises from manifestations of this negative attitude in diverse forms - which are, if anything, more prevalent in terms of post-birth neglect than pre-birth elimination.

Doctors involved with extensive MTP activities estimate the probability of women with more than two daughters seeking MTP would not be more than 2-3 per cent of all abortion seekers.[89] The sample data at Pearl Centre identified 12 out of 514 women probed on family patterns, as having three daughters. PSS data in the 10 FW cum MTP clinics in North India recorded 2-3 per cent of couples seeking a male child. It is to be noted none of these clinics now entertain MTP after sex determination testing.

Abortion Services : Public

In terms of policy, all Government hospitals having obstetric facilities and an obstetrician, ranging from post graduate teaching institutions to district, subdistrict hospitals, CHCs, etc. are eligible to offer MTP services. In addition, all PHCs and maternity nursing homes/ centres in urban areas are supposed to be equipped to handle first trimester MTPs. Over and above this, NGO/ Private sector hospitals are encouraged to have this facility.

However, it is clear that a very good percentage of the hospitals in the country are not offering MTP facilities. As seen earlier, as of 1992-93, there are altogether only 7121 approved institutions for MTP in the country. By

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89 Personal Discussions with Dr. Pai and others.

comparison, in 1991 the total number of hospitals in the country stood at 11,254[90]. But while three quarters of the population is in rural areas, the majority of these hospitals - 7286 - are in the urban areas. Only 4732 are with government or local bodies.[91] Of the public community health facilities - 1563 CHC and 21,641 PHCs - only 1800 institutions are reported to be catering to MTP services.

Further, an insight into the state of PHCs with regard to MTP services is provided by the ICMR survey of PHCs (1989). It found that of 200 PHCs surveyed in 100 districts, 109 PHCs had no MTP facilities; of the remainder 91 only 50 had adequate facilities. Altogether, 88 PHCs had MOs trained to carry out a MTP. The availability of a trained MO and a PHC with adequate facilities were not necessarily matched.[92]

Development of Infrastructure for Services: Past Efforts

A review of the past is necessary to understand the present dilemma. As a health measure on the concurrent list the provision of support for MTP services has devolved on the state health sector. The state health sector is well known to be chronically starved of resources. Further, initially each State/UT set up special Boards to screen applications for permitting qualified physicians/ institutions having the requisite facilities to conduct MTPs. As noted elsewhere, this procedure was replaced in the mid 80s by the state health authorities giving approval. In both cases, the role of the government has been reactive, rather than proactive, in ensuring MTP infrastructure creation. Initially, GOI's support was restricted to framing rules, providing encouragement and guidance to the states/UTs and monitoring their efforts.

There was renewed consciousness in the early eighties of the impact of unsafe abortion on maternal health and mortality. Also, of the slow progress of legal abortion in the country which had plateaued at around half a million, (with less than 4000 institutions approved and less than 8000 trained doctors of which under 2500 were in PHCs), more than a decade after the legislation enactment. In contrast, Japan had within a couple of years trained 8000 physicians and set up a special support organisation for the speciality anticipating a mere million abortions a year after its post-war Eugenic law.[93]

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[90] Foundation for Research in Health Services (1993) *Health Monitor*, Ahmedabad, p.108.
[91] *Ibid.*
[92] ICMR (1991) *Evaluation of Quality of Family Welfare Services at PHC Level*, New Delhi, p.17.
[93] FPAI, *op cit.*

Accordingly, policy recommendations for the Seventh Plan health and family welfare component stressed the provision of MTP services in all PHCs; and, in urban areas, in all maternity homes and centres. It was advocated that the Central government provide appropriate financial support for the purpose, making MTP services an integral part of MCH services and closely linked to the antenatal programme.[94] GOI was already encouraging states and UTs to ensure at least 1 trained physician and suction equipment in every PHC in the country to undertake first trimester abortion.[95]

The Seventh Plan categorically called for all PHCs in the country and all maternity homes and centres to be providing MTP services by the end of the Plan period: It also outlined thrust for training programmes to improve the delivery of services. MTP was to be considered an integral part of MCH. However, in the Seventh Plan the MCH budget declined to 22 per cent of the FW outlay in the Plan. But within its MCH allocation MOHFW suballocated Rs.30 million to MTP services.[96] In 1986-87, MOHFW formulated a central scheme for the Expansion of MTP Facilities by providing GOI funds on a year to year basis. These provided for:

- the creation of a MTP Cell at the State HQ, where MTPs exceeded 10,000
- training of doctors in MTP techniques;
- supply of MTP suction machines.

Earlier in the previous year, a provision of Rs. 15/- per MTP case had been indicated to provide for drugs and dressings.

The funding pattern outlined in the expansion scheme has been most modest: Rs. 1 is given for the support of a MTP Cell for everyone MTP performed, a total expenditure of Rs. 100 per trainee doctor to a maximum of 20 trainees per training centre a year; the pattern of assistance for the purchase of MTP suction equipment is dependent on the states/UTs requirements and the availability of funds.

In execution, the limited MCH budget in the Seventh Plan was virtually hijacked by the Immunisation programme - which acquired the status of a

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94 *Report of the Working Group on Population Stabilisation and MCH* .Seventh Five Year Plan, 1984.

95 Association of OBYGN, (1982) *Fifth Annual Scientific Conference and Joint Symposium on Recent Advances in MTP*, October.

96 Chhabra, Rami and Monica Sharma (1989) ''Women and Health''. Paper prepared for National Perspective Plan for Women (Mimeo).

Technology Mission and overriding priority on the scarce MCH resources. Meanwhile, the post of AC (MTP), available with GOI for MTP specific monitoring and coordination of MTP efforts, had to be sacrificed to accommodate other Mission-related needs. Without a nodal officer and the high pressure concentration on the externally supported Child Survival Programme MTP was even more neglected.

For two years after the announcement of the scheme, no disbursements could be made. Only from 1988 were allocation of funds for the expansion of services indicated. These did not include any provision for drugs and dressings. Further, the paltry nature of the amounts - a range of Rs. 10,000 - 30/40,000 for most states towards the support of a MTP cell at the headquarters; Rs. 2000-38,000 a year for the training budget could not arouse enthusiasm. With details, not forthcoming regarding training conducted and equipment needs, the states use of funds for purchase of suction equipment also lagged. Funds for equipment were specifically earmarked for ISI marked MTP suction aspiratiors and there was some confusion with regard to this. Subsequently, this component was affected by a revision exercise of the ISI standards relating to MTP suction equipment. With this funds disbursement from GOI was suspended for two years. The 80s, which had started out on a promising note to place MTP on the health services map, eventually became a lost decade for MTP improvement efforts.

Present Allocations and Funds Availability for MTP

At present, the scheme for expansion of MTP services is continuing on the earlier basis. i.e. Re. 1 per MTP case for the support of the MTP cell and Rs. 100 per trainee for MTP techniques. Table 15 shows the allocations from 1988-89 to 1993-94. It is to be noted that with the exception of the current year allocations have ranged between Rs. 27 lakhs - 50 lakhs for the entire country. States expenditures, though not available, have been even lower. Not because resources were not needed, but because the low quantum, delays and confusion on specifications, deprioritised MTP within the multitude of matters needing State bureaucratic attention.

Now, in 1993-94, when there is some evidence of central level bureaucratic concern with MTP issues, an allocation of Rs. 15 million has been made. It includes Rs. 11 million for drugs and dressings at the old rate of Rs. 15 per MTP case. Also available is a WHO $300,000 grant for equipment supply, including imports, for which MOHFW is required to give specifications. But

on the other hand, there is continuing ambivalence on the part of international, and some bilateral (chiefly USAID) donor agencies to fund MTP services or MTP equipment supply. USAID has not included MTP in its major Family Welfare project in Uttar Pradesh. Similarly, World Bank has not funded MTP equipment and operation theatres within its Safe Motherhood Project, despite GOI request for the same.

Table 15
Allocation of Funds for Expansion of MTP Services

(in '00000 Rs.)

Year	MTP Cell	Suction Aspiration	Training of Doctors	Drugs & Dressings	Total
88-89	4.9	36.4	3.2	-	44.0
89-90	5.9	18.4	3.1	-	27.5
90-91	7.5	22.1	3.1	-	32.7
91-92	7.5	29.2	3.1	-	40.0
92-93	NA	NA	NA	-	50.0
93-94	7.5	29.1	3.1	110.2	150.0

Source: GOI, MOHFW, Unpublished data.

Private : Legal

The figures routinely published by GOI do not provide the Govt./NGO breakup of institutions approved to perform MTPs. But States/UTs have details. In the case of Maharashtra, which accounts for 22 per cent of the approved institutions, there are 2.3 NGO institutions carrying out MTP services; in Uttar Pradesh, the largest state accounting for the maximum MTPs, the situation is exactly the reverse: 2.5 Govt. institution for every NGO approved to undertake MTP. It is apparent however, that the number and contribution of NGO approved institutions to MTP activities has been somewhat limited so far. This is evident from GOI circulars to States/UTs encouraging increased NGO involvement in the efforts to expand MTP services. As also from the fact that the two major NGO networks at present offering MTP services in the country account for only about 12 per cent share of the overall MTP performance.

But, as seen from the analysis of variation of providers, the private sector physicians play a notable role, much of which may be unreported/unrecorded.

They are the preference of a very large proportion of the clientele. The ICMR study indicates that they could be catering to at least as many women as catered to by government doctors, if not more. The contribution of the private sector doctors could, therefore, easily be around a quarter to half a million. Although, as analysed elsewhere, this is unlikely to be fully reflected in MTP reports.

Amongst the NGO organisations providing MTP services, three frontrunners merit a special look:

- Parivar Seva Sanstha (PSS), which did 49,168 MTPs over the calendar year 1992 or the equivalent of about 8 per cent of the legal MTPs conducted in the country in the year;
- The Health Promotion Society in Bombay whose solitary clinic (Pearl Centre), has cumulatively handled a quarter of a million MTPs from inception to date; and yearly averages 45 per cent of Bombay's total MTPs;
- Family Planning Association of India (FPAI) which has the largest voluntary sector network of clinical family planning services; and therefore, considerable - though largely unrealised - potential for MTP work.

Parivar Seva Sanstha

PSS, a non-profit organisation, introduced to India the specialist agency concept for MTP, when it started in 1979 with a single MTP clinic. It has also pioneered the publicising of the availability of reliable, safe and confidential MTP services in its clinics, thus breaking down social taboos in regard to advertisement of abortion services. By 1987 it was able to upscale (with external funding) to 21 clinics in 7 states and 1 UT. In 1992, external funds still constitute 40 per cent of its resources, but PSS was also able to earn 50 per cent of its budget from fees in 1992.

For the last 5 years PSS has also received some government support. This constitutes 9 per cent of its income in 91-92. The GOI grant is for starting up and running 10 clinics for MTP cum Family Welfare services in the 4 northern backward states, including districts having the lowest contraceptive prevalence rates in the country.

Thus, as of 1993 PSS has 31 static and 3 mobile clinics. These contributed 49,168 MTPs over the calendar year 1992 - a share equivalent to roughly eight per cent of the reported MTPs in 92-93. In terms of per institution average, the

number works out to 1536 MTPs per institution or about 6 per working day as against MTP in 3 working days noted in government institutions. However inputs are also much higher and therefore not really comparable.

MTP earnings represent two thirds of a PSS clinic's income and are reported by PSS as the key to its self sufficiency effort. PSS charges a graded fee depending upon the location of the clinic and the duration of the pregnancy. The rates range from Rs. 190 for an early 1st trimester to upto Rs. 700 for a second trimester. Due to financial constraints, there is only a small provision for waiving or subsidising charges in really needy cases. A major criticism of the PSS initiative relates to whether this quality private sector service grounded with considerable inputs is affordable by the poor. PSS's own data show two-thirds of its clientele with income below Rs. 1000 per month. Even so, this is not a below poverty line group.

Since 1987-88 PSS has also revised its strategy, in deference to local community needs. It now aims to provide medical competence and quality care for broader reproductive health care, social marketing and educational activities to promote family planning and (of late) Aids-prevention.

A major challenge faced by PSS has been the grounding of the abovementioned 10 clinics in known resistant areas. A recent independent evaluation of these clinics has complimented the organisation on successfully maintaining quality of care standards. It is worth noting that at the end of 4 years the average performance per clinic in the backward heartland is 1630 or 6.6 MTPs per working day - even higher than the organisation's general average. Nevertheless, it has faced difficulties in securing timely release of government funds. Earlier also, its training programme for medical practitioners, a solitary initiative by a private sector organisation in this field, ran into difficulties, for lack of sufficient funds beyond the project-period provided for by the Population Crisis Committee (USA).

The government-supported 10 MTP cum FW clinics located in some of the country's most difficult areas, provide a valuable insight into funding and time requirements before financial viability is assured for alternative MTP delivery channels. The non recurring cost of each clinic has been around Rs. 2.70 lakhs; a recurring per MTP deficit grant was expected to subsidise each MTP to the tune of Rs. 537 in the first year reducing progressively each year to Rs. 86 in the fourth year. In actual practice the deficit proved a little higher in the first year and lower in the fourth; but it has needed to be continued for a minimum of another year or possibly two. This, despite an external evaluation certifying PSS's good

management and performance. It is estimated that in the case of a successful clinic of the PSS model type the recurring cost of expenditure at breakeven point is expected to be around 7 lakhs. This is considered feasible to be generated in a 5-6 year trajectory heading to an annual workload of 2400 MTPs at an average cost of Rs. 300 in the final year.

PSS costs are clearly considerably higher than some other successful NGOs. Its staff patterns provide for 9-13 persons, depending upon location and workload. This includes 1-2 gynaecologists, 1 anesthetist, 1 counsellor alongside 1 staff nurse, 1 ANM and 2 fieldworkers, besides other support staff (and manager for the larger unit).

However PSS Clinics are observed to be models of better management, with a distinct emphasis on clean surroundings and cheerful, sympathetic and efficient handling of patients. They are also reported to be catalysing improved, cheaper services availability in the vicinity of their clinics/towns where PSS clinics are known to be operating.

Data from PSS indicates they are attracting younger (70 per cent below 30 years) lower parity (2-3) women, predominantly within the 1st trimester (93 per cent) - which is consonant with the national trend, but more accentuated. Most importantly the clientele is seen to include significant proportions of the ordinarily more difficult to reach segments, such as minority groups and unmarried girls needing total assurance of anonymity.

However, a negative aspect is the high percentage of repeat abortions - one third of all clients across the clinics. But a redeeming aspect is that the overwhelming majority of these, are those who have had only one prior abortion. More persuasive efforts for linking contraceptive cover through still greater stress on counselling aspects and sex education, together with reinforcement of traditional cultural values for the young, emerge as a necessary focus for the future - not only for PSS, but in general for those concerned with improving MTP services while reducing its incidence.

Another interesting point to note from the PSS experience is that mass media has proved an important referral source. But while in earlier years it provided the maximum references, this has subsequently, tapered down to 22 per cent, pointing to saturation levels with this source. Doctors and Chemists continue to play a substantial role - about a quarter of clients come through this route; promoters and sales persons bring another 15 per cent. But significantly, the role of friends and revisits has mounted to 30 per cent, highlighting once again that word of mouth spread of positive reports based on satisfactory

experiences is the most important component of IEC.[97]

Health Promotion Society - Pearl Centre, Bombay

Started in 1974 as a self-generating no-profit-no-loss institution, Pearl Centre Family Hospital was also, initially, funded by an external grant. Its moving spirit is Dr Dutta Pai, a former Professor of Preventive Medicine and Special Officer at MCD, Greater Bombay. Dr. Pai came to the MTP programme with a deep involvement in the delivery of family planning services. Starting at a cost of Rs. 70 for a MTP, the charge has now been moved upto Rs. 90 for an OPD procedure. This Dr. Pai asserts is just a little above his cost price, making the centre self-supporting.

Over the first half of the 80s, Pearl Centre averaged 15,000 plus MTPs a year. The figure has been escalating steadily. Now for the past several years, it is around 30,000 a year or over 100 MTPs per working day. This is about 45 per cent of Bombay's total MTP performance. Dr. Pai is the only full-time doctor, but is supported by a team of six doctors who are part-time, paid on a per procedure basis. Each doctor thus averages 13-14 MTPs a day, which is over the maximum fatigue threshold. Dr. Pai cites conviction, communication and care as the three bridges for success in MTP.

An IIPS doctoral thesis study of a 2 per cent sample of the 27,400 women receiving MTPs in 1992 at Pearl Centre shows the majority of women to be in their late 20s; in an income group between Rs. 1000-3000 per month; the majority of women and their husbands below matric; 92 per cent not working, majority with 2 living children. 8 per cent are known to be unmarried. But given the nulliparous status of a number not so identified, Dr. Pai suggests the real extent could possibly be around 12-13 per cent. 90 per cent of the cases are in the first trimester. By and large, the pattern is synonymous with the various studies and data trends.

With nearly a quarter of a million MTPs since inception and the highest workload in the country at a single point, this institution offers itself as a natural training focal point. However, this has not happened so far. Personality conflicts could possibly be a cause.

Dr. Pai has a scheme which projects a replication of his type of centre in every district of the country, wherever a centrally located carpet area of 3000

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[97] Parivar Seva Sansthan (1988) *Anubhav - Experience in Community Health*, Ford Foundation, New Delhi: Reports of PSS, including evaluation of Govt. aided Clinics of PSS. amd personal discussions with PSS Senior Management.

sq ft. is available on rent, plus a loan of Rs. 5 lakhs (estimated in 1987) can be provided to a doctor or administrator. (Rs. 2 lakhs is estimated as required for equipment and furnishings, 2 lakhs for the space and 1 lakh as working capital). He projects a three model scenario wherein further expansion and replication can be envisaged within 2-5 years depending upon the level of inputs. The scheme was submitted to GOI in 1987 for setting up 400 District FW Hospitals and 10 FW Training Centres (with an additional loan of Rs. 8 lakhs each). But apparently, it did not find any response. Meanwhile, Dr. Pai continues indefatigably at Pearl Centre and is now set to expand the network privately in Bombay itself. [98]

Family Planning Association of India (FPAI):

Although, the oldest and largest family planning volunteer network in the country, having a string of urban clinical family planning services and a very large rural project covering several states, FPAI's role in MTP has been quite limited, so far. MTP services are offered at only 18 of the FPAI's country wide network of clinics. These were started as MTP centres. But like PSS, FPAI has also broadened earlier single focus eforts into Comprehensive Model FP clinics.

MTP performance by FPAI has stagnated at around 18000 a year for the last several years. The FPAI President frankly admits FPAI doctors "don't want to do an MTP without providing contraceptive cover," despite her circulars urging relaxation. However, 95 per cent of MTP acceptors at FPAI do adopt one or another of the FP methods. In one leading FPAI clinic in Delhi there were 1786 MTP cases over 1992-93; the majority, were in the age group 25-30; followed by 30-35: There were only 3 cases below 20 & 39 over 40. Nearly 1000 women accepted IUD and another 750 tubectomy.

FPAI's approach to MTP is one of abundant caution. It only takes 1st trimester abortion - that too below 10 weeks, referring all 2nd trimester cases to other government hospitals. It also refers all "interfered" cases. There is a downward trend noted in many of FPAI's urban clinics, which is attributed to increasing competition in service availability through other organisations.

An interesting issue that emerges from problems cited by FPAI in expanding MTP services in some centres is the legal requirement for expensive equipment like the Boyle's apparatus for anesthesia which costs upwards of Rs.

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[98] Personal discussions with Dr. Pai, IIPS doctoral thesis (AK Sinha): and Health Promotion Society's Family Welfare Hospital - One in Every District 1986, Bombay.

60,000. This escalates the initial investment required to equip a centre for MTP services. The Boyles apparatus has not been used even once in 13 years in one of FPAI's major clinics in Delhi, since it only does early first trimester abortions. But another smaller branch in the city, that was operating without it on the premises, faced closure after an inspection identified the lacuna.

FPAI which is an IPPF affiliate is now more attuned to support MTP work since the IPPF's Jubilee assembly in New Delhi last year. This emphasised abortion as a focal point of programme support within the IPPF's agenda for the nineties. [99]

Private: Illegal

As noted earlier, there is considerable extent of safe (but illegal) abortion occurring through physicians otherwise trained and equipped to carry out MTPs, but failing to follow procedures of recording and reporting.

In addition, there is a considerable level of illegal abortions of varying degrees of safety: as for instance those conducted by trained govt. physicians in private clinics or homes where facilities are lacking, or by private doctors lacking the requisite training and/or the requisite standards of hygiene/equipment in the places in which MTPs are conducted.

As the ICMR rural study on illegal abortion has established, the majority of abortions are conducted using indigenous methods by local practitioners of different types, of whom the most predominant category are the dais, trained and untrained. Earlier studies have also highlighted the extensive role of the dai or the traditional birth attendants in the provision of induced abortions at the village level. An ICMR in-depth case study of illegal providers notes that in under-served tribal and rural areas, women have no choice but to depend upon these illiterate, but available traditional practitioners. These case studies reveal some of the crudest, even inhuman methods and materials being used by unauthorised, totally illiterate and untrained dais; who, nevertheless, have the confidence of 'and proximity to' the local populace. [100]

The ICMR rural study further reveals that abortions done by indigenous providers outstripped those provided by doctors in the 2 states for which it was able to get specific information. Besides, dais, other providers of unauthorised

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[99] FPAI reports; personal discussion with Ms. Wadia, President, FPAI and other senior executives of the organisation.

[100] ICMR, "Traditional Practitioners of Delivery and Abortion in Tribal and Non-Tribal Areas of Orissa" (Mimeo)

services were practitioners of Indian systems of medicine, chemists and even witch doctors, ojhas etc.

Paramedics also contribute a significant percentage of illegal abortions: nearly 13 per cent of the total abortions for which information had been compiled by ICMR. The ANMs/LHVs use modern methods - mainly dilation and curettage learnt from doctors. They are reported as having the requisite skills to assess gestation and completeness of abortion. They are also aware that the MTP act prohibits them from conducting MTPs.[101] The dais and the ANMs/LHVs expressed themselves to be reluctant providers, doing it as a favour or social responsibility. Nevertheless, they received payment for the same. The dais received remuneration in cash or kind.

Amongst the literate unauthorised providers, the proportion of males was significant, but altogether, women turned predominantly and preferentially to female providers within the private illegal framework.

Illegal procedures are found to be mainly carried out in either the providers' homes or the clients' homes. ANMs/LHVs were also found to be making use of PHC/clinic facilities after office hours; or even having arrangements with the doctors' private clinics.[102]

Untrained physicians from different systems of medicine, operating out of small shop establishments in small mofussil towns and urban slums are a fairly large category within the illegal providers. One leading manufacturer of MR kits admits to a sale of about 50-70,000 a year (each kit is estimated to be used for 25-30 procedures). Another major manufacturer reports a smaller offtake: of less than 1000. Most of these sales are to "small doctors who would not like to identify themselves for the same."[103]

Nearly half the sales are in the North where contraceptive prevalence is the poorest. It is noteworthy that Bihar with poor contraceptive cover and one of the poorest networks is described as a particularly "good market". MR procedures are not wholly reflected in the official MTP figures as GOI has no provision for supply of MR kits and therefore few MRs are performed in the public sector. These could possibly account for around 1.25 million terminations.

It is to be noted that an MR procedure, done at an early gestational period, is acknowledged to be the safest of MTP techniques. But untrained physicians

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[101] ICMR (1989) op. cit., pp.125-146.
[102] *Ibid*
[103] Personal Communications: MR Manufacturers.

in shop establishments are not confined to MR alone. D&C has been the classic technique of inducing abortion in India, to the extent it is being performed by LHVs/ANMs also, who have picked up the technique from working with doctors. Electrical suction aspiration is also used. Most physicians are believed to be handling first trimester abortion and referring second trimester cases to government hospitals. But at the same time the most dangerous beyond 20 weeks gestation cases also turn to the private physician or the traditional practitioners of various types.[104]

A multicentric study on Septic Abortion conducted by ICMR in 27 teaching hospitals in 81-82 revealed that nearly 80 per cent of abortion cases that had turned septic and been brought to the hospitals had been induced at unauthorised places. While the number of septic cases is substantially lower now, they are by no means eliminated[105]

The methods used by illegal providers range widely: from D&C, vacuum aspiration, MR & the use of oral modern medicines to herbal concoctions, insertion of twigs & other foreign bodies/herbs/roots vaginally; intra-muscular injections, heat applications, massages of different kinds; witchcraft etc. The in-depth case study by ICMR documents a number of hair-raising methods. For instance, an abdominal massage in which the naval region is smeared with kusum or castor oil, followed by an abdominal massage with two thumbs that locates and presses the foetus till a cracking sound is heard. If bleeding does not immediately follow, the massage continues for 2-3 hours daily till bleeding occurs. If the bleeding continues beyond a week the woman is merely given a special root mixed with fried rice to stop it.[106] Another technique is the insertion of the roots and leaf veins of a local creeper, smeared with opium, high in the vagina upto the womb.[107] Yet another uses a piece of bamboo stick, the tip of which is wrapped with a cloth that has been soaked in Arakha juice and sun dried; this is inserted into the vagina and left there for 8-10 hours. Alongside decoctions of dried ginger, pepper powder are given with hot tea or milk to relieve the pain.[108] Erbolin tablets given orally, are frequently used by traditional midwives in Tamil Nadu.[109]

It is both sobering and heartbreaking to think that very sizeable numbers of women remain vulnerable to primitive manipulations of this kind. Although

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104 ICMR (1989) *op cit.*
105 Personal Discussions
106 ICMR (mimeo) *op cit.*
107 *Ibid*
108 *Ibid*
109 ICMR (1989) *op cit.* p.115

technically, legal and safe abortion is available to them, free of cost.

Training

The liberalisation of the law in 1971 had anticipated the creation of an annual demand of 5 million legal abortions. The prompt creation of adequate medical infrastructure and trained qualified manpower was a clear, emphatic concern from the outset. We have already noted the inadequacy of the physical infrastructure and trained manpower. This section explores the factors contributing to the lacuna of sufficient trained physicians.

Training of doctors in MTP techniques is conducted at 162 designated MTP Training Centres across the country. These institutions - which have been involved in MTP training since the early 80s - are from amongst the A type Post Partum (PP) centres i.e. hospitals which have been provided special inputs under the GOI's Post Partum programme and are conducting more than 3000 obstetrics and abortion cases a year. As of 1989-90 there are 554 PP Centres in the country, of these 230 are in the A type category. These include 2 post graduate teaching institutions, 106 medical colleges, IOI District Hospitals, 31 Voluntary Organisations hospitals and 10 that are run by local bodies.[110] Those PP centres conducting more than 500 abortions a year are the ones approved for MTP training, although obviously all others are equipped and could also be responsible for work in this area. There are over 1000 sub-district hospitals with PP facilities, which could also be capable of contributing to MTP facilities & training.

A training curriculum designed by GOI is available with the States/UTs. This covers two different categories of medical doctors: Category I covers physicians with a postgraduate diploma or degree in OBGYN or doctor with at least three years OBGYN experience likely to work in hospitals with major surgery facilities; Category II is for physicians with little or no experience in OBGYN. For both categories the training comprises of theory and practicals. A minimum of 25 procedures, independently conducted under supervision, is mandatory under the MPT rules and regulations.

The curriculum is quite comprehensive. It includes methods of gynaecological examination with special emphasis on estimation of uterus size and position; selection of patients; counselling; different techniques of first trimester MTP, including MR, suction aspiration D & C; contraceptive cover with training in

[110] Government of India, (1990) *All India Hospitals Post Partum Programme, Annual Report, 1989-90*. MOHFW, New Delhi.

IUD insertion minilap and tubectomy; abortion sequelae and follow up care; demonstrations of second trimester and concurrent sterlisation techniques; and, attendance of under-five clinics for both categories of doctors. Category I doctors get further inputs on the more advanced pregnancy termination methods and surgical techniques including recanalisation, where possible. Earlier, the course was of a month's duration. More recently GOI has indicated that it can be compressed to a fortnight, provided 25 MTPs can be conducted in this duration.

It is possible that the time factor has been a constraint in getting busy doctors away from their clinics for as long as a month. However, it cannot fully account for the general lack of enthusiasm and attention displayed by Government health systems to MTP training so far. By contrast, when PSS ran a MTP Training programme it found that a selection of 44 doctors had to be made from amongst 1600 applicants for 44 seats.

Earlier discussion has covered the meagre allocations for MTP expansion of services including for training of doctors, that too available only since the late 80s; A country wide allocation of Rs. 0.3 million a year (Table 15) technically provided for 3000 doctors to be trained each year. The wide gap between what was expected and occurred is obvious. It is notable that no provisions have existed for the travel and stay of doctors assigned for MTP training. Shortages and delays in TA/DA payments at state and below levels are well known. Participants, often, have to invest their own funds/subsidise time away from home, given the available levels of per diem. In the circumstances, travel to far off institutions is a disadvantage.

At the same time the meagre institutional support (Rs. 100 per trainee per course to a maximum of 20 trainees and 1 course per institution) is too inadequate for the institution to devise and offer any imaginative package of training materials and aids to stimulate the trainee's interest. No well produced training manual is made available to the trainee to refresh memory on the compressed technical course. The training is therefore observed to be of a minimal, practical "observe and do" kind.

But the practical experience aspect also has problems, given the limited MTP workloads of most institutions. In medical colleges, where resident students are also required to undergo training in MTP as part of their general obstetrics training, preference is known to be accorded to the house residents. This has led to a further disenchantment with the training courses amongst the doctors from public health systems.

The gap between the available trained physicians at the PHC level, the first referral point, (under 3000) and the number of PHCs eligible to offer services (over 21,000) is enormous. If this is to be met in the 8th Plan, another 18-19 thousand doctors will have to be trained. Unless training facilities exist at the district and subdistrict level travel, other logistics could be impossible to sustain.

Further, there is no provision, at present, to encourage training of private physicians who constitute such a significant sector of the providers. Even the Indian Medical Association (IMA) which has a membership of 90,000 doctors, more than a quarter of these women and extensive training programmes for contraception promotion and sterilisation, has done no awareness raising or training activities in MTP techniques.

Finally, there is the question of the paramedics (and the trained dais). As seen earlier, these health functionaries also constitute a significant category amongst the "other providers" thus contributing to the growth of illegal abortions. There is, at present no evidence of any thinking as to whether and how this segment can be weaned away from illegal practice.

Licensing

The MTP (Amendment) Rules 1977 which are presently applicable, specify the experience or training required for a medical practitioner to qualify for registration to undertake MTP procedures as:

(a) not less than 3 years of practice in OBGYN for a medical practitioner registered in the State Medical Register immediately prior to MTP enactment;

(b) for a medical practitioner registered on or after the enactment, completion of six months as house surgeon in obstetrics and gynaecology; or

1 year hospital experience in obstetrics and gynaecology; or

training at a hospital or institution approved for the purpose, which includes assistance in the performance of 25 MTPs.

(c) Post graduate degree or diploma holder in obstetrics and gynaecology, registered in the State Medical Register.

With regard to approval of the place for carrying out the MTP procedure the government has to be satisfied of:

(i) safe and hygeinic conditions; and

(ii) provision of (a) an operation table and instruments for carrying out

abdominal and gynaecological surgery; (b) anesthetic, resuscitation and sterilisation equipments; (c) drugs and parenteral fluids for emergency use.

The rules lay out a detailed protocol for the submission of applications for approval of registration of an institution. This is to be made on Form A to the CMO of the District. After due verification, the district health authorities make a recommendation and forward the same to the state health authorities. The state health authorities, in turn forward the application to the State administration, as the state government is the specified authority in the MTP rules empowered to accord the approval. This process can take from several months to over a year. There is widespread dissatisfaction at all levels with this process. It is cited as one of the major reasons for a lagging interest amongst institutions/ practitioners to register[111]. Approval is accorded on Form B. Thereafter, the place must prominently display the registration. It can be inspected at any time. The certificate of approval can be cancelled or suspended if the CMO is satisfied that any deficiencies exist.[112] A prescribed format - FORM C - has also been provided for securing the written consent of the pregnant woman/guardian of a minor/lunatic for carrying out the termination. (See Appendix III for Forms A, B and C).

Furthermore, the Central Govt. has framed MTP Regulations, applicable since October 1975, which provide in minute detail the specified format for recording and reporting every termination. There is a prescribed format (Form I) in which the medical practitioner(s)- according to the gestation of the pregnancy - must certify the performance of the MTP and reason for it, within three hours of carrying out the procedure. Form I, alongside the signed consent form, is required to be kept in an enveloped marked Secret. This envelope must also bear the name and address of the medical practitioner, the serial number given to the termination in the institution's admission register; and the date and time of the termination. This has to be sent to the head of the institution: who in turn, must forward a weekly statement on Form II.. In rare cases - where a pregnancy termination has to be carried out elsewhere than at an approved place - the intimation of the same, in detail, is required to be sent on the same day; or, failing that, on the next working day, by registered post to the Chief Medical Officer of the State.

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111 Discussions with State Health Authorities and others in Uttar Pradesh and Maharashtra

112 "Extract from Gazette of India", Part II, Section 3, Sub-Section (1), Ministry of Health & Family Planning, October 18, 1975.

Every approved institution is required to maintain an Admission Register in Form III, which is a secret document to be kept in safe custody and not open to investigation under any circumstances other than under the authority of: (i) the Chief Secretary in the case of a departmental enquiry, (ii) A First Class Magistrate with jurisdiction over the area of the hospital/institution in the case of an offence; (iii) The District Judge having jurisdiction over the local area of the institution, in the case of a suit or other action for damages. Entries in the Admission Register are required to be made serially, with a distinguishing serial code for each calendar year. No other record of the termination identifying the woman is to be maintained anywhere else; all other medical records have to deal with the assigned serial number only. The Admission Register and all other papers are required to be destroyed after five years in the case of the Register, and three years after the termination in the case of other papers dealing with it. (See Appendix IV for Forms I, II and III).

There is considerable default in record keeping and reporting noted. The cumbersome procedures are quoted as a major detriment to widespread willingness to register, even where medical practitioners have the training and experience and the means to organise the needed facilities, equally, they are the reason for considerable under reporting as analysed in earlier sections. Although the colossal gap between the bureaucratic vision and ground realities is well known, the rules and regulations were not reviewed or amended for over a decade and a half. Only recently a review of the law, rules and regulations was conducted by the Centre and the States. The exercise has not led to any substantive changes in the offing, beyond agreement to ensure that in the second trimester MTP, a gynaecologist may be involved; and that licensing of institutions be decentralised to the district, with the constitution of a medical team for the purpose.

Equipment

Improved safety records for abortions in developed countries are, in part, attributable to the almost complete replacement of sharp curettage procedures by suction curettage procedures for first trimester abortions. This together with an overwhelming movement towards earlier first trimester abortions, by women well aware of the increasing dangers from any delays, has brought about dramatic improvements.

Suction curettage - which is extensively used in China also - is well established to require less cervical dilation; it poses less risk of uterine injury or

of retention of the products of conception. It is also a simpler skill to learn.

Menstrual Regulations (MR) is a variant of vacuum aspiration upto 6-7 weeks after the last menstrual period or even before the pregnancy is established. No anaesthesia or dilation of the cervix is normally required. It is usually performed with a special 50ml manual syringe (but any other vacuum source can be used). It is a safe, simple and low cost procedure that is being done by trained paramedics, as well as doctors, in a number of countries. It usually takes 3-5 minutes depending upon the condition of the uterus and the skill and experience of the service provider.

In India, despite the emphasis on changeover to the suction curettage technique since the 80s there has been a lag, as noted earlier. Public sector equipment replacement/expansion has been considerably hampered by both financial constraints and modalities. These have included non-disbursement of funds/late receipt by the relevant state department of GOI funds; non-availability of state budget resources; in some states differing purchase guidelines from the Centre and the State, the former insisting on ISI certification and the latter on local, lowest tender.

Moreover, these efforts at equipment supply have been confiined to the public health sector. No attention has been paid to devise any scheme to encourage private sector practitioners to switch to suction curettage. Similarly, no provision has existed for the supply of MR equipment and the rendering of MR services through public sector facilities.

Another fundamental problem has cropped up over the last several years, raising issues with regard to the availability of suitable indigenously manufactured suction equipment. Closer attention to the question of ISI certification brought into view the fact that prevailing standards of MTP equipment specifications did not differ from those of general surgical use suction equipment, although medical requirements were actually different.

Experts point out that drainage of fluids from lungs, for instance, is a different proposition from extraction of the products of conception which include some solid matter. The dynamics of vacuum development of MTP are therefore very different: vacuum has to be built fast and maintained continuously to work efficiently and safely.

An Expert Group constituted by MOHFW in 1991 accordingly reviewed the existing standard IS 4533 and assisted the Bureau of Standards to revise the specifications for MTP specific apparatus. These have been issued in 1992 as IS 7080 (Part I, II and III). Part I covers manual suction apparatus; Part II

covers electrical cum manual and Part III electrical suction apparatus.

Manufacture to these specifications is not yet standardised. It is reported that so far only one manufacturer has been able to secure the ISI certification. Although import of equipment is also possible through WHO funds earmarked for the purpose, costs of imported models are four to eight times the price of various indigenous models in the market. There is also the question of after-sales maintenance and servicing which is a crucial requirement for long term serviceability of suction equipment. Therefore, the snarl in equipment supply has been continuing over the current year.

The Indian Institute of Technology (IIT) which has assisted the Expert Group and the Bureau of Indian Standards (BIS) in setting up the new technical standards is convinced that quality production with back up maintenance arrangements can be swiftly assured within the country, providing the volume of demand is projected to Indian manufacturers on an assured basis. Special dyes need to be fabricated for quality components which would be a feasible proposition for manufacturers only when volume orders are forthcoming.

Machines with dual functions - electrical and manual - appear to be more difficult to make satisfactorily at the first instance. But there is no problem of independent quality improvement in both the manual and electrical type of apparatus. There is ambiguity about the Ministry's interest in either type, given that allocations at present are for composite suction apparatus. Given the erratic electrical supply in most areas, back-up of manual suction apparatus is vital.

The IIT already has an established quality testing laboratory with basic facilities for testing. It is presently testing Copper Ts and other contraception -related devices/equipment for MOHFW. It is felt that with quite small inputs it could quickly begin to function as an intermediate quality testing facility and technical back-up for indigenous manufacture. Central procurement and distribution, after quality assurance, is being sought by many states and is recommended by the technical experts to get matters moving quickly. Decisions on this front are still under consideration.

There is some difference of technical views with regard to the type of canula to be used for MTPs. The new BIS standards cover the manufacture of both stainless steel and flexible plastic. The former has the advantage of being sterilised by boiling. The latter has to be disinfected by immersion in a disinfectant solution. There is mixed medical opinion regarding greater safety of one over the other. In developed countries the flexible canula is a disposable item after a single procedure. But with proper care and disinfection it is claimed

to be usable 15-20 times. In India, when used, it is often used for many more procedures. A professional technical assessment in the context of Indian circumstances remains yet to be made on this issue, which is fairly critical for the equipment manufacture. In the case of MR procedures, flexible canula only are used.

New Technology

A medical technical issue that yet lies ahead is the decision whether India should introduce RU486, the antiprogestine abortion pill, which provides a medical alternative to instrumental or surgical intervention for early first trimester pregnancy.

RU 486 is now in wide use in France, the country of manufacture. It has also been registered for clinical use in UK & China. In all 3 countries the drug is licensed for use in MTP with the recommendation that it be administered in conjunction with a uterotonic prostoglandin analogue injected or used as a vaginal pessary. In USA, pro life groups had succeeded in banning its import in 1988. However, earlier this year the case for the import of RU 486 for personal use has been re-opened for re-examination by FDA under presidential order.

In France, the product's licence has been expanded since November 91 to include inducement of labour in cases of intrauterine foetal death and as a priming treatment prior to prostoglandin use for second trimester abortion.

In India, ICMR has completed phase II clinical trials and has moved into an expanded phase of clinical trials that are expected to be completed within 2 years. ICMR is already optimistic about a decision for its introduction in India and possibly the Indian MTP programme, after 2 years.

The completed ICMR study involved 455 women. It has demonstrated 94.5 per cent success rate for terminations within 1-2 weeks of the missed period and 89.6 per cent success rate within 2-4 weeks. The Indian study used a third of the dose being given in France and U.K. i.e. 200 mg. of RU486 followed by 5 mg of prostoglandin gel. This dosage registered a significantly lower proportion of subjects having lesser duration of bleeding days than those with 600 mg/RU486 and 5mg prostoglandin gel. There were no differences in immediate or delated complications, but 16 subjects sought medical advice due to various reasons. The only serious side effects noted in this study was one subject requiring one unit of blood for heavy bleeding. 4 subjects had

incomplete abortion which had to be completed by suction aspiration. 9 did not complete the treatment and 1 carried the pregnancy to full term and delivered a normal child.

A number of medical doctors - including Magsaysay Award winner, Dr. Banoo Coyaji, who participated in the ICMR trials - are hailing the RU 486 as a scientific breakthrough for women.

However, a number of women activists have voiced serious reservations. Attention is drawn to the fact that RU486 is administered in France under a protocol of a minimum of 4 clinical visits, with strict medical supervision and with a number of tests to exclude liver and cardiovascular ailments. These are not likely to take place in India although infective hepatitis and amoebic hepatitis is fairly common. Further, there is concern about the high incidence of incomplete abortions. Thus, its availability as an OTC drug, available at the periphery in the health delivery system, is questioned in the prevailing circumstances, where women's access to health services is limited and there is no follow-up. Timely deliberation on these concerns is warranted at this stage.

SUMMING UP AND POLICY IMPLICATIONS

3

The principal point emanating from the foregoing analysis is the collosal gap between the utilisation of legal MTP services and the actual level of abortion demand existing in the country.

Major Public Health Issue

Abortion emerges as one of the most significant and, hitherto, neglected public health issues in the country, keeping in view:

- The scale of the absolute numbers, which appear to be in the region of I I million abortions annually. Appropriate health services back up is needed for the nearly 6.7 million induced abortions, and also for a sizable proportion of the over 4 million spontaneous abortions, which need to be factored into any health care scenario that seeks to develop a comprehensive approach to women's reproductive health care;
- A ratio of 10-11 illegal abortions for each MTP performed;
- A minimum of 15,000-20,000 deaths annually, practically all preventable;
- The submerged statistical iceberg of various types of morbidity, ranging from chronic ill health and infertility to minor and major sequaelae of unsafe abortions.

MAJOR WOMEN'S RIGHTS ISSUE

The other principal point, the review of abortion figures and trends indirectly throws into relief is, the intense gender inequality faced by most Indian women within their conjugal relationship. The very high incidence of spontaneous abortion on the one hand; and, on the other, the frequently noted problems of health/psychological trauma in the MTP data highlight the fragile status of women's reproductive health in India.

Alongside, these very aspects bring to the fore the total disregard by considerable numbers of Indian men for their wives' health situation, manifested in the lack of consideration to the woman's physical or psychological competence to bear a child at a particular point of time.

Women's desperation not to further compound their own (and their family's plight) by carrying to full term "yet another" or a "too soon" pregnancy remains the major motivating factor for abortion demand in India. Thus, abortion forms an excellent proxy indicator for unmet need for contraception - in considerable part, arising out of the failure of the family planning programme to provide compassionate, caring and culturally acceptable and accessible contraceptive services.

As much, abortion is to be seen as a key proxy indicator of the low personal and sexual autonomy of most Indian women - paradoxical as this may appear at first. Although, the foregoing review has not explored the realm of conjugal rights issues, the linkage with them is clear cut. The lack of legal rights and social sanctions to the married woman who chooses to refuse her husband's sexual advances is fairly well-known. However, this has not yet emerged as a basic human rights issue violating the woman's absolute and fundamental right to bodily integrity.

The right of the woman to say no to sex (even within matrimony) and her right to contraceptive cover are critical aspects of women's reproductive freedom and sexual health issues within the present Indian reality and cultural perspectives. In converse, an equally important aspect is the need for societal focus on creating an ethos for male restraint and responsibility as an essential part of the social codes governing sexuality.

Society's failure to recognise and deal with abortion as a virulent symptom of the individual male's unbridled sexual gratification, indulged in without due responsibility to his partner and to the larger community, lies at the root of its expanding numbers.

In the nineties, India is having nearly twice as many abortions as were estimated in the seventies. While a small fraction of the increase is due to a higher incidence of outside wedlock sexual intercourse, the overwheling majority is due to unwanted and mistimed pregnancies *within* wedlock. This too is a cause for grave social concern.

MTP a Non-Issue for Women's Organisations

Unfortunately, a matter of such vital public health importance has received scant public attention and enlightened post-legislation support. The MTP Act came up in the liberal spirit of a health and humanitarian measure to ensure the well-being of women. But even after more than two decades of the event, access to safe abortion services is non-existent for the majority of Indian women. Ironically, the same appears to be a non-issue for most organised women's groups and others charged with the improvement of women's well-being.

It is a disturbing fact that, so far, no systematic efforts have been made to raise public consciousness on the critical need for the improved availability and quality of MTP services as an integral part of reproductive health care, while there is simultaneous effort to reduce its long-term need.

Lack of Educational Efforts

Public educational campaigns to make the MTP Act widely known, as well as the knowledge regarding the locations where free, safe services are available; and, to create an awareness on MTP-related safety issues have been conspicuous by their absence. Beyond the odd poster or pamphlet and an occasional TV film spot, no coordinated thrust has been attempted to bring about greater utilisation of safe MTP services, even where existing. NGO initiatives have been of limited scope also. Sex education itself remains a taboo. Therefore, addressing responsible sexuality issues has not even figured.

General Neglect of MTP Services

Public health and women's development administration, as well as women's organisations alike, have failed to draw attention to the non-implementation of the MTP Act in certain parts of the country. Similarly, they have not focused attention for changing the haphazard and inequitous distribution of recognised MTP centres, which make them virtually outside the reach of substantial segments of the women's population across many parts of the country. On the other hand, enunciation of policies for expansion of services, particularly in rural areas, has not been backed by the needed financial allocations and targeted actions to ensure this happening.

The *suo moto* efforts of the NGO sector have been extremely limited. The government's efforts to encourage NGO participation have remained largely confined to the issuing of circulars urging for it. Where government support has been given to NGOs, it has been paltry and dilatory. Experimentation for the creation of alternative delivery mechanisms for MTP services has not taken place at all in this country. The private sector, although considerably large in real terms, has had a limited role within the recognised institutional framework. Outside the stringent legal frame, it has been fairly divided between safe and unsafe provision of services.

In sum, the prevailing scenario leaves little doubt that, like the family planning programme which India had the distinction of also pioneering but subsequently failing to ground successfully, India's remarkable lead in the legal provision of MTP services has now collapsed into a dismal situation. Its rescue cannot be delayed any more.

Failure of Family Planning Efforts

The underlying assumption in the MTP Act 1971 was to make available the

facility of safe abortion to Indian women. While the intent of the Act is praiseworthy, it is seen that it has not been able to attract into its fold most women seeking abortion, for a variety of reasons which are social, psychological, as well as medical. At the same time, it is to be remembered that the vast majority of Indian women seeking MTP are adult married women with children, whose motivation for limiting or spacing the family has not been backed by either access to/or use of effective contraception; or, for whom contraception itself has failed.

This reflects more on the organisation of family planning services and the prevalence of social conditions within which contraceptive use is difficult. While MTP is not a method of family planning, in India its interconnection with women's family planning needs is organic. The high level of abortion prevalence is the most clinching proof of the Indian women's desperate need and search for family planning measures, that is not met satisfactorily. However, the decline in the proportion of MTP acceptors taking a concurrent contraceptive measure, even at a high motivation point, only highlights something wrong with the *way* the contraceptive methods are being pushed on the women.

More of the Same Will Not Do

The preceding sections have clearly shown that only a fraction of women needing abortion seek the help of a recognised MTP institution. It has also been seen that compared to available health facilities, public and private, only a few are recognised to offer MTP services.

However, a mere increase in the number of recognised institutions and trained physicians per se does not provide the answer, as seen from the trends of MTP institutions and performance; as well as from the analysis of the average efficiency level of institutions. A number of organisational, management, technical and financial issues have been identified. These need to be urgently addressed, for rectifying some of the problems within the existing service delivery mechanisms, both in the public and the private sector. Streamlining of the present delivery system - which is functioning far below its optimum capacity as indicated by this analysis - could in itself generate a considerable momentum from the illegal into the legal mainstream.

But, considering the multi-faceted dimensions of the problem and the size of the gap between the legal and illegal incidence, it is imperative to recognise that a mere linear expansion of facilities with suction equipment and trained physicians is not likely to provide solutions on the scale needed for the current level of needs. Linear expansion will also not help to address the various types

of constraints experienced by women seeking pregnancy termination. Radical changes, within a fairly short time-frame, are therefore desperately called for. These will not come with simply more of the same.

Inadequate Legal Framework

This raises a critical primary issue that must be addressed, even prior to any examination of what can be done to streamline the present system within existing parameters. That is, whether the legal framework provided by the existing MTP Act, Rules and Regulations, from which all policy and programme directions flow, is capable of catalysing the conditions for adequate solutions.

The foregoing analysis has highlighted the twin thrusts of the MTP legislation: decriminalisation of the action of termination and medicalisation of the procedure of termination. Both were instituted for the purpose of ensuring the betterment of the beleaguered woman with an unwanted pregnancy. Notwithstanding this, the Act has provided in a variety of ways for a superior position and the guaranteed protection of the medical practitioner, even at the expense of the woman's interests.

Medical Profession Safeguarded but Disinterested

The medical profession has been totally safeguarded when functioning under the aegis of the MTP Act, as indicated earlier. Further, it has been accorded an exalted role *vis a vis* the woman. The woman must furnish details of why she is seeking a termination. The medical practioner assesses the woman's genuine need based on "the pregnant woman's actual and reasonable foreseeable environment", as also, the steps to be taken based on assessment of her pregnancy stage. Furthermore, the Act condones a qualified medical practitioner shortcutting procedures in an emergency situation; or, a medical practitioner without the necessary MTP training or experience acting to save a woman's life. But at the same time, it virtually denies the woman's right to emergency relief from any quarter other than a medical practitioner. Notwithstanding such safeguards to medicos, substantial numbers of the medical profession choose to quietly function outside its protective cover, mainly, on account of the plethora of strict regulatory directions that have been devised by the Central Government. This reduces the regulatory procedures outlined under the law into something of a mockery. Further, most recognised public institutions are found to be not delivering to their full potential, mostly because the physicians are not interested in providing free MTP services, or in following these strict procedures.

Women Victims of Medicalised Approach

At the same time this legal policy of intense medicalisation of the MTP procedure, has driven very large numbers of women outside the ambit of safe, legal MTP services to surreptitious, often criminally organised abortion arrangements. Thus, the advantages of liberalisation of the law have been outweighed by the medicalisation of the procedure in circumstances of poor medical controls and poor medical motivation. Low accessibility of physicians, particularly for poor women; their unsympathetic attitudes and treatment in the free public facilities; as well as, the predominant male gender of doctors are amongst the key factors identified as creating a push away from qualified delivery service. Alongside, the elaborate reporting and recording requirements, ostensibly for confidentiality have created cumbersome conditions. At the same time, there is a lack of essential privacy and secrecy in the interpersonal interactions with the woman, causing dissatisfaction with the services.

Another issue is why doctors should receive a blanket indemnity under the MTP Act - instead of functioning as for other surgical procedures and taking the consequences of any default or neglect. Yet another point of issue is, why qualified medical practitioners of the Indian system of medicines who are now being trained and allowed to carry out sterilisations - and in any case, conduct deliveries - should not be permitted to be trained in MTP techniques also.

However, little cognisance has been taken of issues of this type in such recent reviews, as have taken place of the MTP Act, Rules and Regulations. From present indications the thrust appears to be towards a still greater emphasis on recording, reporting and also medicalisation. One of the few changes now contemplated is to ensure a gynaecologist is mandatorily consulted for second trimester termination.

Anachronistic Approach to Women

Despite the extensive evidence available of the MTP Act's shortfalling of women's needs, the nation has failed to note it. Or that, with the passage of two decades what may have once appeared to be a progressive measure, likely to ensure the betterment of women's health and contribute to her ability for self-determination, has become something of an anachronism at this historic point of a worldwide struggle for women's rights.

By superimposing the medical practitioner's assessment of the woman's needs, the MTP Act has left the door open for more restrictive interpretations

in changed political, social and demographic contexts, and subject to an individual practitioner's whims in any circumstances. Thus, the Act's failure to acknowledge the woman's right to her bodily integrity and to be the final arbiter of her own destiny (within limits of medical safety) is a major drawback.

As also noted earlier, the MTP Act explicitly denies the woman the right of securing emergency relief from just anyone able to provide it in time of dire crisis, by making pregnancy termination through anyone other than a medical practitioner a punishable offence under the IPC. In a country where more than ninety percent of babies are still delivered by persons other than medical practitioners - and nearly half of them in untrained hands - barring the retrieval of the products of conception through non-medical channels can hardly be considered a safeguard imposed solely in the woman's interest. The question arises, why those considered competent to be trained to handle a woman's delivery cannot be trained to handle an early termination, at least?

Women's Perspective Key

A thorough review and amendment of the MTP Act, strengthening its primary intent as a measure for women's health and well-being; as well as, updating it to reflect this within the context of the woman's human right to her person and life destiny, appears to be a critical requirement.

A re-examination of the MTP Act, from the prism of the women's perspective, would point to a fairly different flow of policy direction than what is taking place at present for a law which seeks "to provide terminations of certain pregnancies by registered medical practitioners and for matters connected thereof"

For instance, legislation primarily concerned with securing women's safety in pregnancy termination would be compelled to draw on established scientific assessments which underline that for maximum safety and efficiency, the availability of pregnancy termination services should be such as to facilitate legal induction by skillful operators at an early gestation stage. It would have to bear in view the body of expert opinion pointing out that the greater the barriers to achieving this criteria the greater the hazard to the health of the woman. Termination of a pregnancy on request during early first trimester would then be a logical approach, alongside a more stringent approach to second trimester requests; as also, licensing of institutions and physicians to conduct it.

Early Termination Key to Women's Safety Issue

Both from the perspective of women's safety and service costs, an overriding consideration is for pregnancy termination to take place as early as possible. Technically and administratively too, it is acknowledged by experts that first trimester abortion is a very different operation from that of a second trimester. But the only differentiation the present MTP Act makes *between* the two trimesters is to require the concurrence of a second medical opinion in the case of a second trimester termination. Similarly, the Rules and Regulations set guidelines in great detail regarding a host of bureaucratic procedures. But attempt no differentiation in the requirements for facilities, training, equipment etc. *between* the procedures for the two stages of gestation. This is a cardinal flaw.

The clubbing of both first and second trimester terminations, along with the stress on medicalisation, has served to shrink the availability and accessibility of safe services, thus virtually denying the woman legal services at the point when risks are minimal to her. A differential approach in tackling approval of institutions and skills for carrying out the procedures in first and second trimester is, therefore critical. It must go beyond a decision for PHCs to have a trained physician to perform first trimester termination.

In this connection, it would be also useful to explore alternative delivery channels being used by other countries, such as, training of paramedics (even possibly trained birth-attendants, who are already engaged in the task but doing it unsafely) for MR. Only in a better organised community and first referral health services delivery system, could new medical approaches through technologies like RU 486 also have a place. However, holistic training of paramedics/TBAs is an essential prerequisite for their use in MR services.

Upholding of Woman's Right to Person as Pre-eminent.

Greater policy clarity is required on a number of emerging potential conflict issues between different aspects of women's rights, and their rights versus the "societal good". As for instance, the handling of the issue of sex determination tests so that it does not impinge on the right to abortion. It is necessary to consider whether the wholesale banning of sex determination tests will only succeed in driving the problem underground.

A brand new controversy is hovering on the horizon, triggered by the recent judgement of the Karnataka High Court, wherein a minor girl's right to bear a child has been upheld, but with strong pro-life and misplaced medical

arguments. Adolescent and illicit pregnancy, although still marginal in the Indian context,is a growing phenomenon that will have to be dealt with in ways that contain it, but clearly abjure any possibility of coercion.

An old controversy is whether insistence for concurrent contraception - sterilisation or IUD insertion for effective contraceptive method provision to a multipartity woman or one seeking repeat abortions - can be ever justified.

These issues need to be given a thorough thought at this juncture, and a coherent set of guiding principles evolved through public debate. In a woman sensitive perspective the bottom line has to be the woman's natural right to her person and of bodily integrity which must be absolute and pre-eminent by law.

Role of Education and Counselling for Responsible Sexuality

Concomitant with rights will be the need for an educational framework for their responsible assertion in consonance with accepted social norms. Educational and counselling processes that actively assist women - never coerce - to understand their options and consequences, and, gently persuade them to take responsible and rational decisions protecting their own interests but also harmonising these with the greater societal good, are therefore vital for the very enjoyment of such rights. In particular, sex education for *both* sexes promoting responsible sexuality, which must not become an euphemism for contraceptive protected promiscuity, is essential.

In this context, the role of the media emerges as a most critical aspect. Carefully callibrated public education campaigns will need to be mounted on a scale. These must promote information on required details to make safe MTP services widely known, retaining restraint and an emphasis on cutural values. Precise information is needed on the where and how of safe MTP services; the far greater safety of early trimester MTP services and the great hazards of later abortions; the dangers and the ethical issues surrounding sex determination tests; the danger of early pregnancies, of irresponsible sexuality etc.

As importantly, there is need for instituting watchdog mechanisms with regard to the media, in particular the electronic and film media. These are seen today to be fuelling an undesirable emphasis on sexuality, and generally legitimising liberatarian behavior patterns through exposure to alien values and life styles, to which the young are particularly vulnerable. Guidelines will need to be laid down as to how to balance the use of the media for the spread of needed information on MTP and sexuality issues, while restraining and effectively countering programming that contributes to the break-down of responsible sexual mores.

Lack of Funds for MTP

Policy perspective is an essential key. But the physical grounding of these perspectives will require the backing of substantial funding for a meaningful take-off. It has been noted that, in the past, the MTP programme has had such erratic and limited funding, that eventually even the small amounts available to it have not been absorbed, because of general administrative neglect and apathy. Earlier, MTP suffered on account of being subsumed in MCH services, which itself faced a paucity of funds.

Now, substantive funds - mainly provided by international and bilateral sources - are available for strengthening Maternal and Child Health (MCH) activities, in particular Safe Motherhood (SM). Improvement of family welfare services is separately receiving financial fillip. But the MTP services issues continue to remain outside the pale of either. The earlier US position on abortion-''the Mexico City Policy'' - had cast a long shadow on international funding over the late eighties. Despite the recent US reversal of policy, the change has yet to percolate to the international project level. Earlier negotiated projects such as SM in India - do not support MTP related matters. Certain international agencies continue to have a political position on abortion. The government needs to resolve this issue with donor agencies, and to ensure that MTP services find an integral place within the reproductive health care package.

Integrated versus Vertical

A most critical aspect to consider is whether MTP services developed as a vertical thrust within the public health services can be effective. At present, the MTP Cells responsible for coordinating and monitoring MTP arrangements vary in being located between the Health and Family Welfare Depts. at the State level. They are practically non-functional. At the Centre, the subject is amongst those in the charge of the Deputy Commissioner, Technical Operations, Dept. of Family Welfare, making its focus mainly on technical issues.

For MTP services to effectively reach women, it will need to be integrated/ coordinated with both Safe Motherhood and Family Welfare activities, within the overall framework of the MCH programme. MCH in turn, has to escalate in the health delivery system priorities, given the disproportionate impact pregnancy and pregnancy-related matters have on the Indian woman's health status.

A clear enunciation of an integrated perspective of women's reproductive

health-care needs is necessary. It would end the present bureaucratic confusion and compartmentalisation with regard to budget allocations and administrative responsibilities on the grounds that MTP is a woman's health measure and not a family planning measure. This coordination is also vital to ensure the availability of more sophisticated emergency back-up services, such as transportation, blood transfusion etc. without duplication of resources.

A MCH Cell exists at the Centre and similar MCH Cells headed by MCH Programme Officers have come into existence at the State level. It is therefore both unnecessary and unwise to create a parallel MTP coordinating and monitoring structure, which would be both cost intensive and dysfunctional for integrated health delivery services. In any case, the paltry funding of Rs. 1 per MTP case, settled nearly a decade ago, can hardly achieve this objective. It needs to be increased several fold to create a meaningful administrative support at the state level. Therefore, a better strategy certainly would be to strengthen the MCH Cell suitably and assign it specific responsibilities in MTP coordination, supervision and monitoring.

Increased Budgets for Drugs and Dressings

As observed in the foregoing sections, the underfunding of the MTP service component has had a negative bearing on all its dimensions: infrastructure, facility development; training of skilled manpower; quantum of cases handled per institution. The only extra inputs provided for the creation of MTP facilities are the meagre training funds and the purchase cost of one piece of suction equipment per institution. This year, after a gap of several years, Rs. 15 per MTP case is to be reimbursed for drugs and dressings. The amount is clearly insufficient for covering even routine medical requirements for the procedure, leave alone making a provision for treating minor and major sequalae that may arise. In the circumstances, institutions are naturally reluctant to take on more than the unavoidable burden of MTPs, considering these to be a drain on scarce resources, already insufficient for frank illnesses and accidents. Similarly, the inadequacy of medical and other emergency support back-up is also a contributing factor to the physician's reluctance to take on risks when there is no personal gain involved. Ensuring timely reimbursement and an increase of the drugs and dressing budget is an administrative measure that is clearly urgently needed.

Enhancement of Training Budget

Similarly, the training budget has to be stepped up to more realistic levels

for its effective implementation. Provision is required to be made for the travel and stay of those deputed for the training. Also, an enhanced budget provision for the institutions' training activities is needed, so that the educational component is actually given alongside the clinical training. Budget provision is needed for the development and provision of appropriate training aids and communication materials, audio-visual as well as print, for both the trainers and trainees. A well produced manual on MTP techniques, counselling and other allied issues given to every trainee at the end of the training, would help reinforce the lessons of the short training period and provide ready reference subsequently.

Increase in the Number of Training Institutions Desirable

A widening of the training base is essential. There is scope to expand the number from the 166 Post Partum centres designated as MTP training centres. Even institutions performing less than 3000 obstetrics and abortion cases a year need to be considered, particularly those at the subdistrict level which would bring the training facility closer to the trainees. If these institutions are carrying a smaller MTP workload, fewer trainees could be trained in each facility. However, their involvement in the training programme itself could possibly act as an impetus to step up their quota of MTP service delivery. It is quite obvious from the earlier analysis in this report, that there is no dearth of MTP cases; only a failure on the part of MTP equipped facilities to attract them.

At the same time, it would be useful to ensure NGO involvement in the training programme, particularly the leading NGOs with demonstrated capabilities in MTP service delivery. Government grants should encourage the development of at least one or two training bases in the NGO sector, as an experiment.

Earmarking certain days in hospitals for MTP services; providing a separate space within hospitals for OPD MTP arrangements are other measures that could be tried to increase the number of cases handled. Paramedical staff could be encouraged to accompany cases on fixed days in their areas, and also allowed to assist and train during the procedure.

Revision of Rules and Regulations Required

Pending a more comprehensive reorientation of the MTP Act, there is need for the government to consider liberalising the Rules and Regulations framed by it. Both the licensing and reporting procedures need to be relaxed. In the case of licensing, government needs to consider a separate protocol for institutions/

medical practitioners for carrying out first trimester MTP only. This should have, for instance, less stringent requirements regarding the range of equipment necessary, as also regarding the need for parenteral fluids for emergency use to be available on the premises, if as long as they are available within reasonable proximity. Further, decentralisation of the process of approval of institutions/ practitioners to the district level is necessary, to telescope the time period involved. Equally, to make the process itself appear to be more accessible and feasible to many practitioners currently resorting to illegal practice in the face of the cumbersome time-consuming procedures. It needs to be considered why inspectorial powers to medical authorities should not be the same as available to deal with institutions performing other surgical procedures.

It is also not clear as to what purpose is being served by the elaborate confidential recording arrangements and reporting procedures required to be followed at present - but which are abandoned with impunity by so many institutions. There is nothing in the MTP Act itself that makes these details mandatory. The law has merely passed the power to make the rules and regulations to the Centre and State governments respectively. Changes have to be placed before the Houses of Parliament for their approval. The government needs to consider the maximum simplification possible to make MTP yet another medical procedure on par with other bodily interventions, wherein the rights and privacy of the individual are part and parcel of medical ethics and protected as such under the general laws governing these issues.

Equipment Issues

There are a number of unresolved issues regarding the availability of standard suction equipment. Technical issues have to be sorted out for the quality manufacture of electrical/dual suction apparatus and components such as the canulae. Decisions are required regarding public funding of MR kits. These matters need to be addressed urgently. The development of indigenous manufacturing competence and its quality assurance testing capability at IIT (Delhi) should be a national priority, given a time bound programme and provided adequate resources. However, in the meantime the supply of needed equipment must not be delayed, wherever trained personnel are available to carry out the procedures. Funds available for imports need to be utilised. An urgent assessment of the situation by the Ministry of Health and Family Welfare is required, with the processes made transparent. Organising the supply and maintenance of proper suction equipment/MR Kits is crucial to improved quality of services.

However, improvement of the quality and availability of MTP services delivery involves many facets. The vision for MTP services must go much beyond a "suction equipment supply and technique training scheme"--which, unfortunately, is all that the MTP programme has tried to be so far, unsuccessfully.

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APPENDICES

Appendix I

The Medical Termination of Pregnancy Act, 1971
(ACT No. 34 OF 1971)

[10th August, 1971]

An Act to provide for the termination of certain pregnancies by registered Medical practitioners and for matters connected therewith or incidental thereto.

BE it enacted by Parliament in the Twenty-second Year of the Republic of India as follows:

1. Short title, extent and commencement (1) This Act may be called the Medical Termination of Pregnancy Act, 1971.

(2) It extends to the whole of India except the State of Jammu and Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Definitions In this Act, unless the context otherwise requires,--

(a) ''guardian'' means a person having the care of the person of a minor or a lunatic;

(b) ''lunatic'' has the meaning assigned to it in section 3 of the Indian Lunacy Act, 1912 (4 of 1912);

(c) ''minor'' means a person who, under the provisions of the Indian Majority Act, 1875 (9 of 1875), is to be deemed not to have attainedd his majority;

(d) ''registered medical practitioner'' means a practitioner who possesses any recognised medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956, (102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gyanecology and obstetrics as may be prescribed by rules made under this Act.

3. When pregnancies may be terminated by registered medical practitioners(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,

(a) where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion, formed in good faith, that--

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation 1 Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2 Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub- section (2), account may be taken of the pregnant women's actual or reasonable forseeable environment.

(4)(a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman.

4. Place where pregnancy may be terminated No termination of pregnancy shall be made in accordance with this Act at any place other than--

(a) a hospital established or maintained by Government, or

(b) a place for the time being approved for the purpose of this Act by Government

5. Section 3 and 4 when not to apply (1) The provisions of section 4, and so much of the provisions of sub-section (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

Explanation For the purposes of this section, so much of the provisions of clause (d) of section 2 as relate to the possession, by a registered medical practitioner, of experience or training in gynaecology obstetrics shall not apply.

6. Power to make rules (1) The Central Government may, by notification in the Official Gazette, make rules to carry out the provisions of this Act.

(2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely--

(a) the experience or training, or both, which a registered medical practitioner shall have if he intends to terminate any pregnancy under this Act; and

(b) such other matters as are required to be or may be, provided by rules made under this Act.

(3) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament while it is in session for a total period of thirty

days which may be comprised in one session or in two successive sessions, and if, before the expiry of the session in which it is so laid or the session immediately following, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

7. Power to make regulations (1) The State Government may, by regulations,--

(a) require any such opinion as is referred to in sub-section (2) of section 3 to be certified by a registered medical practitioner or practitioners concerned, in such form and at such time as may be specified in such regulations, and the preservation or disposal of such certificates;

(b) require any registered medical practitioner, who terminates a pregnancy, to give intimation of such termination and such other information relating to the termination as may be specified in such regulations;

(c) prohibit the disclosure, except to such persons and for such purposes as may be specified in such regulations, of intimations given or information furnished in pursuance of such regulations.

(2) The intimation given and the information furnished in pursuance of regulations made by virture of clause (b) of sub-section (1) shall be given or furnished, as the case may be, to the Chief Medical Officer of the State.

(3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of any regulation made under sub-section (1) shall be liable to be punished with fine which may extendd to one thousand rupees.

8. Protection of action taken in good faith No suit or other legal proceedings shall lie against any registered medical practitioner for any damage caused or likely to be caused by anything which is in good faith done or intended to be done under this Act.

Appendix II

MTP Rules and Regulations

MINISTRY OF HEALTH AND FAMILY PLANNING

(Department of Family Planning)

New Delhi, the 10th October, 1975

G.S.R. 2543 In exercise of the powers conferred by section 6 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following rules, namely:-

1. Short title and commencement (1) These rules may be called the Medical Termination of Pregnancy Rules, 1975.

2. They shall come into force on the date of their publication in the Official Gazette.

2. Definitions In these rules, unless the context otherwise requires,

(a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971);

(b) "Chief Medical Officer of the District" means the Chief Medical Officer of a District, by whatever name called;

(c) "Form" means a form appended to these rules;

(d) "Owner" in relation to a place, means any person who is the administrative head or otherwise responsible for the working or maintenance of such hospital or clinic, by whatever name called;

(e) "Place" means such building, tent, vehicle, or vessel, or part thereof, as is used for the establishment or maintenance therein of a hospital or clinic which is used, or intended to be used, for the termination of any pregnancy;

(f) "Section" means a section of the Act.

3. Experience or training etc. For the purpose of clause (d) of section 2, a registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namnely;

(a) In the case of a medical practitioner who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years;

(b) in the case of a medical practitioner who was registered in a State Medical Register on or after the date of the commencement of the Act,--

(i) if he has completed six months of house surgency in gynaecology and obstetrics; or

(ii) unless the following facilities are provided therein, if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or

(iii) if he has assisted a registered medical practitioner in the performance of twenty five cases of medical termination of pregnanccy in a hospital established or maintained, or a training institute approved for this purpose, by the Government.

(c) in the case of a medical practitioner who has been registered in a State Medical Register and who holds a post-graduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

4. Approval of a place.

(1) No place shall be approved under clause (b) of section 4,--

(i) unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and

(ii) unless the following facilities are provided therein, namely:--

(a) An operation table and instruments for performing abdominal or gynaecological surgery;

(b) anaesthetic equipment, resuscitation equipment and sterilisation equipment;

(c) drugs and parenteral fluids for emergency use.

(2) Every application for the approval of a place shall be in a Form A and shall be addressed to the Chief Medical Officer of the District.

(3) Officer of the District is satisfied that the facilities specified in rule 4 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the Government giving the detail of the deficiencies or defects found at the place. On receipt of such report the Government may, after giving the

(4) Every owner of the place which is inspected by the Chief Medical Officer of the District shall afford all reasonable facilities for the inspection of the place.

(5) The Chief Medical Officer of the District may, if he is satisfied after such verification, enquiry or inpsection, as may be considered necessary, that termination of pregnancies may be done under safe and hygienic conditions, at the place, recommend the approval of such place to the Government.

(6) The Government may after considering the application and the recommendations of the Chief Medical Officer of the District approve such place and issue a certificate of approval in Form B.

(7) The certificate of approval issued by the Government shall be conspicuously displayed at the place to be easily visible to persons visiting the place.

5. Inspection of a place

(1) A place approved under rule 4 may be inspected by the Chief Medical Officer of the District, as often as may be necessary with a view to verify whether termination of pregnancies is being done therein under safe andd hygienic conditions.

(2) If the Chief Medical Officer has reason to believe that there has been death of, or injury to, a pregnant woman at the place or that termination of pregnancies is not being done at the place under safe and hygienic conditions, he may call for any information or may seize any article, medicine, ampule, admission register or other document, maintaineed, kept or found at the place.

(3) The provisions of the Code of Criminal Procedure, 1973 (2 of 1974), relating to seizure shall, so far as may be, apply to seizure made under sub-rule (2).

6. Cancellation or suspension of certificate of approval.

(1) If, after inspection of any place approved under rule 4, the Chief Medical Officer of the District is satisfied that the facilities specified in rule 4 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the Government giving the detail of the deficiencies or defects found at the place. On receipt of such report the Government may, after giving the owner of the place a reasonable opportunity of being heard, either cancel the certificate of approval or suspend the same for such period as it may think fit.

(2) Where a certificate issued under rule 4 is cancelled or suspended, the owner of the place may make such additions or improvements in the place as he may think fit and there after, he may make an application to the Government for the issue to him of a fresh certificate of approval under rule 4 or, as the case may be, for the revival of the certificate which was suspended under sub-rule (1).

(3) The provisions of rule 4 shall, as far as may, apply to an application for the issue of a fresh certificate of approval in relation to a place, or as the case may be, for the revival of a suspended certificate as they apply to an application for the issue of a certificate of approval under that rule.

(4) In the event of suspension of a certificate, of approval, the place shall not be deemed to be an approved place for the purposes of termination of pregnancy from the date of communication of the order of such suspension.

7. Review:

(1) The owner of a place who is aggrieved by an order made under rule 6, may make an application for review of the order to the Government within a period of sixty days from the date of such order.

8. Form of consent. The consent referred to in sub-section (4) of section 3 shall be given in Form C.

9. Repeal and saving. The Medical Termination of Pregnancy Rules, 1972, are hereby repealed except as respects things done or omitted to be done before such repeal.

New Delhi, the 10th October, 1975

G.S.R. 2544. In exercise of the powers conferred by section 7 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following regulations, namely:

1. Short title extent and commencement. (1) These regulations may be called the Medical Termination of Pregnancy Regulations, 1975.

(2) They extend to all the Union territories.

(3) They shall come into force on the date of their publication in the Official Gazette.

2. Definitions In these regulations, unless the context otherwise requires,--

(a) "Act" means the Medical Termination of Pregnancy Act, 1971, (34 of 1971);

(b) 'Admission Register" means the register maintained under regulation 5;

(c) "approved place" means a place approved under rule 4 of the Medical Termination

of Pregnancy Rules, 1975;

(d) "Chief Medical Officer of the State" means the Chief Medical Officer of the State, by whatever name called;

(e) "Form" means a form appended to these regulations;

(f) "hospital" means a hospital established or maintained by the Central Government or the Government of Union territory;

(g) "section" means a section of the Act.

3. Form of certifying opinion or opinions.

(1) Where one registered medical practitioner forms or not less than two registered medical practitioners form such opinion as is referred to in sub-section (2) of section 3 or 5, he or they shall certify such opinion in Form I.

(2) Every registered medical practitioner who terminates any pregnancy shall, within three hours from the termination of the pregnancy certify such termination in Form I.

4. Custody of forms. (1) The consent given by a pregnant woman for the termination of her pregnancy, together with the certified opinion recorded under section 3 or section 5, as the case may be and the intimation of termination of pregnancy shall be placed in an envelope which shall be sealed by the registered medical practitioner or practitioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place or the Chief Medical Officer of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.

(2) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 3, there shall be noted the serial number assigned to the pregnant woman in the Admission Register and the name of the registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked "SECRET".

(3) Every envelope referred to in sub-regulation (2) shall be sent immediatelyi after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.

(4) On receipt of the envelope referred to in sub-reglation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.

(5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, a weekly statement of cases where medical termination of pregnancy has been done in Form II.

(6) On every envelope referred to in sub-regulation (1), pertaining to a termination of pregnancy under section 5, shall be noted the name and address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and such envelopes shall be marked "SECRET".

Explanation. The columns pertaining to the hospital or approved place and the serial number assigned to the pregnant woman in the Admission Register shall be left blank in Form I in the case of termination performed under section 5.

(7) Where the Pregnancy is not terminated in an approved place or hospital, every envelope referred to in sub-regulation (6) shall be sent by registered post to the Chief

Medical Officer of the State on the same day on which the pregnancy was terminated or on the working day next following the day on which the pregnancy was terminated:

Provided that where the pregnancy is terminated in an approved place or hospital, the procedure provided in sub-regulations (1) to (6) shall be followed.

5. Maintenance of Admission Register.

(1) Every head of the hospital or owner of the approved place shall maintain a register in form III for recording therein the admissions of women for the termination of their pregnancies.

(2) The entries in the Admission Register shall be made serially and a fresh serial shall be started at the commencement of each calendar year and the serial number of the particular year shall be distinguished from the serial number of other years by mentioning the year against the serial number, for example, serial number 5 of 1972 and serial number 5 of 1973 shall be mentioned as 5/1972 and 5/1973.

(3) The Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

6. Admission Register not to be open to inspection. The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorised by such head or owner and save as otherwise provided in sub-regulation (5) of regulation 4 shall not be open to inspection by any person except under the authority of.

(i) in the case of a departmental or other enquiry, the Chief Secretary to the Government of a Union territory;

(ii) in the case of an investigation into an offence, a Magistrate of the First Class within the local limits or whose jurisdiction the hospital or approved place is situated;

(iii) in the case of suit or other action for damages, the District Judge, within the local limits of whose jurisdiction the hospital or approved place is situated:

Provided that the registered medical practitioner shall, on the application of an employed woman whose pregnancy has been terminated, grant a certificate for the purpose of enabling her to obtain leave from her employer:

Provided further that any such employer shall not disclose this information to any other person.

7. Entries in registers maintained in hospital or approved place--No entry shall be made in any case-sheet, operation theatre register, follow-up card or any other document or register (except the Admission Register) maintained at any hospital or approved place indicating therein the name of the pregnant woman and reference to the pregnant woman shall be made therein by the serial number assigned to such woman in the Admission Register.

8. Destruction of Admission Register and other Papers.-- Save as otherwise directed by the Chief Secretary to the Union territory Administration or for in relation to any proceeding pending before him, as directed by a District Judge or a Magistrate of the First Class, every Admission Register shall be destroyed on the last entry in that Register and other papers on the expiry of a period of three years from the date of the termination of the pregnancy concerned.

Appendix III

Medical Termination of Pregnancy Rules, 1975

FORM A

[See sub-rule (2) of rule 4]

Form of application for the approval of a place under Cl.(b) of Sec.4

1. Name of the place (in capital letters)
2. Address in full
3. Non-Government/Private Nursing home/Other Institutions*
4. State, if the following facilities are available at the place

   (i) An operation table and instruments for performing abdominal or gynaecological surgery.

   (ii) Drugs and parenteral fluid in sufficient supply for emergency cases.

   (iii) Anaesthetic equipment, resuscitation equipment and sterilization equipment.

Place: Signature of the owner of the place.

Date:

* Strike out whichever is not applicable.

MEDICAL TERMINATION OF PREGNANCY RULES, 1975

FORM B

[See sub-rule (6) of rule 4]

Certificate of approval

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971).

Name of the Place, Address and other discriptions

Name of the owner

Place: to the Government of the_____

Date:

FORM C

(See rule 8)

I,_____daughter/wife of_____

aged about_____years of_____

(here state the permanent address)

at present residing at_____

do hereby give my consent of the termination of my pregnancy at

(State the name of a place where the pregnancy is to be terminated).

Signature

Place:

Date:

(To be filled in by guardian where the woman is lunatic or minor)

I,_____son/daughter/wife of _____ aged about _____ years of _____ at present residing at _____(permanent address) do hereby give my consent to the termination of the pregnancy of my ward _____ who is a minor/lunatic at _____

(place of termination of pregnancy)

Signature

Place:

Date:

Appendix IV

MEDICAL TERMINATION OF PREGNANCY REGULATIONS, 1975

FORM I

(See Regulation 3)

.....

(Name and qualification of the Registered Medical Practitioner in block letters) .....

..... (Full address of the Registered Medical Practitioner) I, ...

..... (Name and qualification of the Registered Medical Practitioner in block letters) .....

(Full address of the Registered Medical Practitioner) hereby certify that *I/we/am/are of opinion, formed in good faith,, that it is necessary to terminate the pregnancy of .....

..... (Full name of pregnant woman in block letters) resident of .....

..... (Full address of woman in block letters) for the reasons given below**,

*I/we hereby give intimation that *I/we terminated the pregnancy of the woman referred to above who bears the serial No ..... in the Admission Register of the Hospital/ approved place.

Place:

Signature of Registered
Medical Practitioner

Date:

Signature of Registered
Medical Practitioners

(i) In order to save the life of the pregnant woman.

(ii) In order to prevent grave injury to the physical or mental health of pregnant woman.

(iii) In view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(iv) As the pregnancy is alleged by pregnant woman to have been caused by rape.

(v) As thee pregnancy has occured as a result of failure of any contraceptive device or method used by the married woman or her husband for the purpose of limiting the number of children.

Note Account may be taken of the pregnant women's actual or reasonably foreseeable environment in determining whether the continuance of a pregnancy would involve a grave injury to her physical or mental health.

Place:
Date:

Signature of the Registered
Medical Practitioner
Signature of the Registered
Medical Practitioners

* Strike out whichever is not applicable.

** Of the reasons specified items (i) to (v) write the one which is appropriate

FORM II

[See Regulation 4(5)]

1. Name of the State
2. Name of Hospital/approved place
3. Duration of pregnancy (give total number only):

    (a) upto 12 weeks

    (b) between 12-20 weeks

4. Religion of woman:

    (a) Hindu

    (b) Muslim

    (c) Christian

    (d) Others

    (e) Total

5. Termination with acceptance of contraception:

    (a) Sterilization

    (b) I.U.D.

6. Reasons for termination: (give total number under each sub-head);

    (a) Danger to life of the pregnant woman.

    (b) Grave injury to the mental health of the pregnant woman.

    (c) Grave injury to the physical health of the pregnant woman.

    (d) Pregnancy caused by rape.

    (e) Substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

    (f) Failure of any contraceptive device or method.

Signature of the Officer in-charge
with date.

FORM III

(See Regulation 5)

Admission Register

(To be destroyed on the expiry of five years from the date of the last entry in the Register)

Sl.No.	Date of Admission	Name of Patient	Wife/ daughter	Age	Religion	Address	Duration of pregnancy
1	2	3	4	5	6	7	8

Reasons on which pregnancy is terminated	Date of termination of pregnancy	Date of discharge of patient	Result and Remarks	Name of Registered Medical Practitioner(s) by whom the opinion is formed	Name of Registered Medical Practitioner by whom pregnancy is terminated
9	10	11	12	13	14

Appendix V

Definitions

GOI	Government of India
OBGYN	Obstretrician and Gynaecologist
RMP	Registered Medical Practitioner
CMO	Chief Medical Officer
CBR	Crude Birth Rate
IPPF	International Planned Parenthood Federation
ICMR	Indian Council of Medical Research
CPR	Contraceptive Prevalence Rate
MR	Menstrual Regulation
MO	Medical Officer
ANM	Auxillary Nurse Midwife
LHV	Lady Health Visitor
PHC	Primary Health Centre
IUD	Intra-Uterine Device
NGO	Non Governmental Organisation
CHC	Community Health Centre
MCH	Maternal and Child Health
IMA	Indian Medical Association
FW	Family Welfare
MOHFW	Ministry of Health and Family Welfare
AC	Assistant Commissioner
ISI	Indian Standards Institutiion
WHO	World Health Organisation
OPD	Out Patient Department
IIPS	International Institute of Population Studies
D & C	Dilation and Curettage
PP	Post-Partum
I I T	Indian Institute of Technology
B I S	Bureau of Indian Standards
F D A	Federal Drug Agency
I EC	Information Education Communication
OTC	Over the Counter

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ABORTION IN INDIA

AN OVERVIEW

Abortion was liberalised in India in 1972, more than two decades ago. Has the MTP Act succeeded in its purpose of providing women safe, legal, medical services for pregnancy termination?

This study provides the first comprehensive look at the current situation. It outlines the dimensions of the problem, focussing on colossal gaps in services.

The review pinpoints abortion as one of the most significant, neglected public health issues of our times; an important proxy indicator of a vast, unmet need for contraception; *and* a sensitive indicator of intense gender inequality within the conjugal relationship.

Women need safe MTP services as a basic human right. Is this too much to hope for even in the late twentieth century? But beyond medical services, lies the urgent need for social conscientisation; in particular, for male sexual responsibility.

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